



R E S E A R C H R E P O R T

AIDS Blood Scandals: What China Can Learn from the World's Mistakes.

September 2007

***AIDS BLOOD SCANDALS:
WHAT CHINA CAN LEARN FROM THE WORLD'S MISTAKES***

ASIA CATALYST

SEPTEMBER 2007

CONTENTS

I.	SUMMARY	2
	POLICY RECOMMENDATIONS	3
II.	THE BLOOD SCANDALS	6
	A. <i>UNITED STATES</i>	7
	B. <i>JAPAN</i>	9
	C. <i>FRANCE</i>	10
	D. <i>CANADA</i>	11
	E. <i>OTHER COUNTRIES</i>	12
III.	CHINA'S EXPERIENCE	14
IV.	LEGAL ISSUES	20
V.	THE ROLE OF GRASSROOTS NGOs	28
VI.	CONCLUSION	30
	APPENDIX: FOUR FREE, ONE CARE PROGRAM	32
	ACKNOWLEDGMENTS	33
	ABOUT ASIA CATALYST	33
	NOTES	34

I. SUMMARY

We should enhance management of blood banks, strictly crack down on upon illegal blood collection, and ban in-hospital infections, in order to curb viruses spread through blood transfusions.
-- Vice-Premier Wu Yi¹

In the early 2000s, a series of articles in the *New York Times* first brought the world's attention to HIV/AIDS in China's Henan province. There and in other central provinces, unsafe blood collection methods spread HIV to thousands of villagers. Since that time, despite continual central government efforts to crack down on illegal blood sales, local blood banks and hospitals continue to engage in risky blood collection practices. Today, China's blood supply remains dangerously unsafe. Around the country, patients who check into hospitals for routine surgery may check out with HIV/AIDS as a result of hospital blood transfusions.

However, China is not alone: many other countries have had similar disasters, and have struggled with how to address them. This report explores their experiences and suggests some ways that China might learn from the world's mistakes.

In the 1980s, thousands of people in the U.S., Japan, France and Canada contracted HIV/AIDS through contaminated blood supplies. These largely avoidable tragedies prompted public outrage in all four countries. The victims of these blood scandals initially sought justice and compensation through their national legal systems. Thousands of cases were filed in various countries, and litigation drew on for years. But while there were some impressive legal victories, litigation in many countries yielded frustrating results both for the victims and the defendants. Not only did some victims die before their legal outcome, but many also lost large parts of their recoveries to attorneys. Governments and courts were burdened by a torrent of litigation. China now faces a similar challenge.

Most countries eventually responded to the blood scandals by holding public investigations. They established national compensation funds. They also took steps to centralize and regulate national blood supplies. All three steps—investigating, compensating and regulating—are mutually reinforcing measures: none of the countries discussed here has had a blood scandal since the 1990s.

Though its unique social, cultural and legal context suggests that some solutions that have worked elsewhere may not be appropriate to China, the overall model—investigate, compensate, and clean up the blood supply—provides a framework that could be adapted to the Chinese context. This report examines blood scandals in the U.S., Japan, France, and Canada, compares their experience with that of China, looks at the guidance offered by international human rights law, and makes recommendations for the future. However, we stress that a comprehensive investigation and a thorough reevaluation of blood regulation are time-consuming tasks. Neither should be a prerequisite for or a condition of the urgent necessity to create a compensation fund. People living with HIV/AIDS have urgent medical and financial needs today, and further delay would only place them in a more precarious position.

While the worst of the catastrophe is in the past, the threat to the future is real. The demand for blood and blood products is expected to increase in China. As demand grows, so will the economic pressures that lead hospitals to buy blood from illegal underground blood-sellers. This in turn will fuel the AIDS epidemic, which has never respected national boundaries. Addressing the threat to China's blood supply and the wrongs done in the past is urgent for current victims of the tragedy, for the safety of China, and for the world at large.

POLICY RECOMMENDATIONS

International assistance: A key recommendation of this report is that China seek and be given international technical and financial assistance in addressing its continuing blood safety issues, and in compensating victims. Chinese experts and experts from countries with personal experience of AIDS blood supply disasters should form an international commission to assess the problem and design solutions.

The following recommendations should be considered in the context of such a larger cooperative effort between China and international partners.

Control of the Blood Supply: China should develop a more centralized and robust regulatory system to regulate the national blood supply. Currently, Chinese law mandates a locally-managed identification system that should prevent repeat or at-risk sellers from participating in the blood donation system. Blood is tracked and units later discovered to be contaminated may be sought out and removed. We recommend extending this tracking capability to the national supply.

The World Health Organization, as well as U.S., Canadian, Japanese and French governments, and international hemophilia and HIV/AIDS organizations with related expertise, should all expand existing programs or initiate new ones to provide technical assistance to China in its efforts to perfect its blood safety systems.

Chinese blood centers and other blood-supply related entities should organize under an association that can facilitate the exchange of information and ensure a more uniform application of government regulations.

Compensation: China's State Council AIDS and STD Prevention Coordinating Committee should establish a national compensation fund for people infected with HIV both directly and indirectly through blood sales and hospital blood transfusions (indirect victims are those who contracted HIV/AIDS from a spouse or parent who contracted HIV/AIDS from the blood supply). The fund should provide:

- a monthly stipend,
- support for families once a wage-earner passes away due to complications related to AIDS,
- payment for funeral expenses,
- psychological counseling, and
- a fund to assist affected families with educational costs.

This program should complement and not abridge existing government programs that provide assistance to HIV/AIDS impacted families. The fund could state that those who accept compensation through the fund waive all rights to sue in the future.

The compensation scheme should provide broad coverage to make it both fair to victims and cost-effective to the government. In regard to the latter, the experience of other countries is that a broad definition of eligible victims saves time and money in the long run, because qualification systems add expensive administrative costs.

Access to Justice: The Ministry of Justice should immediately issue a circular instructing all courts in the country to accept lawsuits on HIV transmission through blood transfusions. If a victim chooses not to accept moneys from the national compensation fund, she or he should still have the right to bring a lawsuit and have it duly processed. Moreover, while a compensation fund might release the government from liability, private actors should be subject to law suits under Chinese law.

Assessment: In order to assess the blood supply problem, members of the UN Theme Group on HIV/AIDS in China should consider convening an international conference in Beijing to discuss how international experience with similar problems could be helpful to China, and to offer assistance to the Chinese Ministry of Health in conducting an internal assessment of the number of people infected with HIV/AIDS through blood sales and blood transfusions.

Civil Society: Because of China's continuing restrictions on registration and functioning of AIDS nongovernmental organizations (NGOs),* UNAIDS should support efforts by Chinese AIDS and hemophilia grassroots groups to advocate for compensation. UNAIDS should establish an association of domestic groups that would allow them to advocate in China under the protection of the United Nations.

International AIDS and hemophilia associations with experience in HIV blood supply outbreaks in their own countries should provide technical and financial support to grassroots AIDS and hemophilia organizations in China.

* See Human Rights Watch, *Restrictions on AIDS Activists in China*, June 2005; available at <http://hrw.org/reports/2005/china0605/>, retrieved August 30, 2007.

Table One: International AIDS Blood Scandals

Country	Number of victims
China ¹	69,000
United States ²	11,384
France ³	6,000
Germany ⁴	3,000
Japan ⁵	2,000
Mexico ⁶	1,844
Canada ⁷	1,400
UK ⁸	1,341
Libya ⁹	426
Australia ¹⁰	206
Netherlands ¹¹	320
Kazakhstan ¹²	100
Iran ¹³	70
Tunisia ¹⁴	64
Morocco ¹⁵	36
Saudi Arabia ¹⁶	35
Iraq ¹⁷	34

Countries for which there are either official data on blood supply infections or reliable media estimates. In many countries, numbers are a subject of controversy. Numbers include only direct victims.

Sources:

¹ This number includes both former commercial blood and plasma donors and recipients of blood or blood products through transfusions. Doctors and AIDS advocates in China have charged that this number is a serious underestimate, and that the true number maybe in the hundreds of thousands. *2005 update on the HIV/AIDS epidemic and response in China*. Ministry of Health of China, UNAIDS, WHO joint report. Beijing: Ministry of Health, 2006.

² From 1981 and 1994. Eric Feldman & Ronald Bayer, *Blood Feuds: AIDS, Blood, and the Politics of Medical Disaster* (New York: Oxford University Press, 1999): 35.

³ Feldman & Bayer, *Blood Feuds*, 109.

⁴ Commission of Inquiry on the Blood System in Canada (Krever Report), released November 26, 1997, available at http://www.hc-sc.gc.ca/ahc-asc/activit/com/krever_e.html, retrieved August 19, 2007: 845.

⁵ As of 1993. Feldman and Bayer, *Blood Feuds*, 64.

⁶ As of 1994. J. Sepulveda-Amor et al., "The Strategy for Preventing HIV/AIDS Transmission via the Blood and Its Derivatives in Mexico", *Salud Publica Mex.* 37 (1995): 624-35.

⁷ As of 1993. Feldman and Bayer, *Blood Feuds*, 141.

⁸ *Commission of Inquiry on the Blood System in Canada (Krever Report)*, released November 26, 1997, available at http://www.hc-sc.gc.ca/ahc-asc/activit/com/krever_e.html, retrieved August 19, 2007: 926.

⁹ Elisabeth Rosenthal, *Quiet. Libya Has an AIDS Problem*, *New York Times*, July 29, 2007 available at <http://www.nytimes.com/2007/07/29/weekinreview/29rosenthal.html?ex=1188705600&en=a4def2001fd83e3ec&ei=5070> retrieved on August 15, 2007.

¹⁰ *Commission of Inquiry on the Blood System in Canada (Krever Report)*, 791.

¹¹ As of 1995. *Krever Report*, 902.

¹² Maria Golovnina, "Health workers jailed in Kazakh baby AIDS death case", Reuters, June 27, 2007 available at <http://www.reuters.com/article/latestCrisis/idUSL27767557> retrieved on August 15, 2007.

¹³⁻¹⁹ As of 1995. Purushottam Narayan Shrestha, "Transmission of HIV through blood or blood products in the Eastern Mediterranean Region," *Eastern Mediterranean Health Journal* 2 (1996): 283-289. Other countries in the region with respective numbers of HIV infections via blood transmission include: Bahrain (5), Cyprus (2), Jordan (19), Kuwait (4), Lebanon (14), Oman (18), Pakistan (5), Palestine (1), Qatar (4), Somalia (4), Sudan (12), Yemen (4).

II. THE BLOOD SCANDALS

This report focuses on the most prominent cases of HIV infection through blood transmission: those that took place in the United States, Japan, France, and Canada from the mid-1980s to mid-1990s [See *Table One*]. The particular reasons why large-scale HIV/AIDS infection through blood transfusions occurred varies from country to country, but a significant factor was the newness of the threat HIV posed to then-underdeveloped systems of blood safety.¹ As one scholar notes, this decade was

one of extraordinary scientific and epidemiological turbulence. It was during this short span of years that physicians discovered and reported the first cases [of HIV/AIDS]... [and] scientists developed a test to detect HIV in blood; and laboratories perfected a method to heat-treat blood plasma and inactivate HIV. Each of these events was subject to scientific and policy uncertainty.²

Despite the challenges posed by the times, the picture is not a pretty one: in each country discussed below, government actors made poor choices that fueled HIV transmission through blood transfusions. While private entities were involved with and often responsible for these tragedies, national governments play an important role in the collection, distribution and regulation of the blood supply. Thus, in all the HIV blood transmission cases discussed here, governments bear a large portion of the responsibility.

To understand the context of the following blood disasters, a brief discussion of the supply, distribution and transfusion of blood may be helpful.

Hospitals began transfusing blood sporadically and with limited effectiveness since the beginning of the twentieth century.³ By the end of World War II, scientists had learned to prevent many of the dangers that had previously plagued blood transfusions, including reducing deadly bacterial infections, and avoiding potentially fatal immune system reactions to the transfused blood of another. Today, in most developed countries, blood transfusions are remarkably safe.⁴ With rapid scientific advances in the last forty years, blood has become a powerful means of saving and improving lives.

In particular, the ability to isolate blood plasma and serum from whole blood through techniques such as centrifugation have enabled doctors to create concentrated “blood products” that could be given to people with chronic blood deficiencies.^{*} These factors are particularly important for characteristics that facilitate clotting. One important example is the radical improvement in the lives of hemophiliacs, whose life expectancy doubled in the 1960s.⁵ This is significant in our discussion because the size of the international hemophiliac population and its reliance on blood products helped to create a lucrative international market for blood products; and because hemophiliacs would become the population most heavily burdened by tainted blood. In some countries, they also emerged as a powerful force in grass-roots movements to demand compensation.

As scientists gradually refined their understanding of blood, the twin demands for blood products from hemophiliacs and for transfusable blood from emergency rooms attracted pharmaceutical companies. As these companies grew, they began to build their influence on how national governments regulated blood. By the 1980s, many countries grew uneasy with the for-profit collection of whole blood, and either created national whole blood collection programs, or turned whole blood collection over to non-profit entities such as the Red Cross. However, the manufacture of blood products, historically viewed differently than whole

^{*}Our definition of the term whole blood includes certain components of blood such as, for example, red blood cells. Blood products, which require more sophisticated processing, include plasma, the liquid serum of blood, and proteins.

blood, generally remained in the private for-profit sector.

Perhaps as a result of the early lack of regulation of the highly profitable blood products industry, it is the use of blood products rather than the transfusion of whole blood that has played a central role in many international HIV blood transmission disasters (though whole blood did play a prominent role in the United States and Canada). Blood products—especially, the sale of blood products—played an especially central role in AIDS infections in China and Mexico. Thus, a brief explanation of the blood product collection process may be helpful.

Hospitals give transfusions of **whole blood** to people who suffer a sudden loss of blood through an accident or through surgery. **Blood products, or plasma**, are harvested through a process in which whole blood is run through a centrifuge and certain parts are “fractionated” or separated out. Because one person’s donation of blood yields little valuable blood product, the whole blood of many donors must be pooled before it is run through the centrifuge.

This process can put blood products at risk of contamination by pathogens. If blood is not carefully screened beforehand, the pooling process allows one person’s HIV-positive blood to be spread into hundreds and even thousands of units of blood product. In some regions, such as in rural areas of China in the 1990s, blood product companies have engaged in the risky practice of re-injecting blood components from the centrifuge back into donors after the plasma has been separated out. This reduces the likelihood that donors will become anemic and enables them to donate again more quickly.

In other countries, many HIV-positive persons who became positive as a result of blood transmission were infected through blood products, rather than through transfusions of whole blood. Hemophiliacs, who rely on numerous injections of blood products over the course of their lifetime, have been at an increased risk of HIV infection through exposure to contaminated blood products.

With this background in mind, we now turn to a chronological examination of HIV outbreaks in blood supplies in the United States, Japan, France and Canada, before moving on to see what light their experiences may shed on similar problems in China.

a. United States

Scholars began warning of an impending blood-supply disaster as early as the 1970s.[†] On July 16, 1982, reports began surfacing in the United States that an immunosuppressive disease was striking hemophiliacs, the primary recipients of blood transfusions.⁶

An in-depth discussion of the reactions of various U.S. private and government institutions to the emergence of HIV in the blood supply is beyond the scope of this article. However, scholars agree that the contamination of the blood supply in the United States was largely attributable to the policies that governed blood donation in the early stages of the AIDS epidemic. In particular, public officials and private

[†] Since at least the 1970s, scholars have debated whether blood systems that operated partly for-profit and partly not-for-profit could safely and efficiently satisfy the increasing demand for blood. In particular, there was concern that the for-profit facets of the blood supply industry would inevitably drive the non-profit elements of blood collection into the more risky, less-civic-minded nature of commercial enterprises (See e.g., Trebilcock et al., “Do Institutions Matter?,” 1413-1415). Furthermore, around this time, government officials in the United States were becoming increasingly distressed about the rapidly rising prevalence of hepatitis in the blood supply (Starr, *Blood*, 225-229). The World Health Organization began warning about the dangers of poor sanitation in the commercial plasma trade in 1975 (Patricia Volkow et al., “Transfusion-associated HIV infection in Mexico related to paid blood donors,” *International Journal of STD & AIDS* 15 (2004): 337-342).

companies reacted slowly to evidence suggesting that members of vulnerable groups such as men who have sex with men or injection drug users, who then comprised a significant proportion of blood donors, should be excluded from blood donation.⁷

The high prevalence of HIV among U.S. blood donors in the early 1980s is evinced by the fact that more individuals there contracted HIV/AIDS as recipients of whole blood than as recipients of blood products. As noted above, most of the victims of contaminated blood supplies in other countries contracted HIV/AIDS through blood products. In Japan, only a few people were infected with HIV through whole blood.⁸ In the United States, though, at least 7,659 non-hemophiliacs were infected with HIV prior to 1995 through transfusions, while the number of hemophiliacs infected between 1981 and 1994 through blood products was roughly half that number.⁹ The total of 11,384 blood-supply-related infections in the United States prior to 1995 is the largest number of HIV/AIDS of any country in that time period.

The high prevalence of HIV/AIDS in the U.S. blood supply would later have tragic repercussions for other countries. Because the United States was at that time the largest exporter of blood and blood products, this HIV-positive blood was spread across the globe, which meant, in turn, that the United States became the source of the global contamination of blood supplies in the 1990s.¹⁰

Although some U.S. hemophiliacs and HIV/AIDS-infected transfusion recipients have alleged that their infections were caused by corporate greed,¹¹ of the four countries discussed here, the U.S. HIV blood transmission disaster actually shows the least evidence of direct corporate involvement. If anything, it was the state that failed to act quickly on advice from the Centers for Disease Control to protect the blood supply—according to some critics, in part as a result of pressure from the blood industry. The U.S. response was further tragically hampered by a plague that often follows on HIV: for years, while tens of thousands of American citizens died, the U.S. president refused to confront or speak publicly about the AIDS epidemic.

The contention of some AIDS advocates that the U.S. moved too slowly is supported by an influential Institute of Medicine report,¹² commissioned by the government, which chose “not to emphasize the moral failings of venality and greed, but rather stressed the institutionally rooted inadequacy of the response of those who should have acted more aggressively in the face of unfolding evidence.”¹³ The Institute of Medicine found that the U.S. system of blood regulation was disorganized, and that American policy leaders should have anticipated, in light of the prevalence of hepatitis, that another viral contaminant could tragically endanger the blood supply. The fact that the U.S., for many reasons, did not act quickly enough to protect its national blood supply has fueled the spread of HIV as a global pandemic.

However, without minimizing the failures of the U.S. government, it is worth noting that most of the U.S. individuals who contracted HIV/AIDS through the blood supply did so before the disease was fully identified and understood by scientists anywhere.¹⁴ No evidence has been found establishing criminal or negligent responsibility on the part of U.S. government officials. However, as Douglas Starr notes,

At every stage of the AIDS epidemic—from openly revealing the link to the blood supply, to putting in place donor-deferral procedures, to virally deactivating plasma products and using the ELISA test—Americans acted more quickly than any others...

Still, given the scope of the tragedy—at least ten thousand hemophiliacs who seroconverted and twelve thousand transfusion recipients who became ill—one must ask whether the American blood establishment could have acted more effectively.¹⁵

A program of donor self-exclusion was adopted in 1983 that greatly decreased the prevalence of HIV in

new blood donations. By 1984, the United States had publicly identified the virus' presence in the blood supply and had promised that a blood test would soon be commercially available. By 1985, the American Red Cross was testing blood donors successfully.¹⁶

Unfortunately, the U.S. acted far less swiftly and effectively in paying compensation, as will be discussed later. And the U.S.'s moves to regulate the blood supply were not swift or robust enough to prevent contaminated blood from being distributed to other countries, with disastrous results.

b. Japan

Once the U.S.' blood supply was compromised, it began to affect the blood supplies of other countries. National politics and commercial interests came into play, fueling the epidemic. Perhaps more so than in any other country, the influence of private industry played a pivotal role in the transmission of HIV/AIDS through the Japanese blood product supply. By the mid-1980s, contaminated blood products transmitted the AIDS virus to about 2,000 hemophiliacs, about half of Japan's hemophiliac population at the time.¹⁷ Japan reacted so ponderously to the emergence of HIV/AIDS in its blood products that some Japanese officials were eventually criminally indicted.

In contrast with the United States, few, if any, individuals in Japan received HIV-positive blood transfusions during the decade after the country's first HIV/AIDS case.¹⁸ However, blood products that were prepared from the whole blood of other nations (principally that of the United States) and imported into Japan were heavily compromised. Instead of moving quickly to treat blood products, Japan allowed the distribution of contaminated blood products longer and with less regulation than other countries discussed in this report. Furthermore, Japanese officials failed to acknowledge or publicize the danger to hemophiliacs of contracting HIV/AIDS, even after there was strong evidence of contamination of the blood supply.

Worse, Japanese government officials became directly implicated in the continuing contamination of the blood supply. Government regulators moved into positions in Japanese pharmaceutical companies, fostering a close relationship between government and the companies they regulated.¹⁹ As would later be the case in France, Japanese officials at the Ministry of Welfare were eventually charged with having delayed the adoption of U.S. heat-treatment technology for twenty months after it was successfully unveiled in the U.S. Apparently, they did so in order to protect the market share of domestic pharmaceutical companies that were trying to develop similar technology. This allegation became the basis of murder charges brought against Dr. Takeshi Abe,²⁰ one of the country's most celebrated hemophilia doctors and a senior health policy adviser.²¹

In the early 1980s, Dr. Abe was Japan's top blood policy adviser and head of a committee at the Ministry of Welfare that formulated policy regarding blood supplies. In early 1983, Baxter Pharmaceutical, a U.S. pharmaceutical corporation, applied for expedited approval to distribute heat-treated blood products in Japan. Green Cross, a Japanese pharmaceutical corporation and the leading provider of blood factor products in Japan at the time, was in the process of developing similar technology and saw the U.S. pasteurization processes as an economic threat.²²

Dr. Abe and his Committee refused to approve an application by Baxter for expedited approval, and instead required that Baxter's pasteurized blood products go through the full, two-year licensure process.²³ While Baxter's application was being processed, Green Cross developed similar heat-treated products. Even though Baxter had applied more than a year earlier than Green Cross, on July 1, 1985, both the Baxter heat-treated products and the recently developed Green Cross heat-treated products were simultaneously

approved by the ministry. Many--if not most--of the Japanese hemophiliacs who contracted HIV/AIDS through transfusions did so during the period when Baxter and Green Cross were waiting for licenses to be approved.²⁴

Worse, even after heat-treated products were approved, Green Cross continued distributing old stores of unheated blood products. In fact, Green Cross was later discovered to have distributed un-heat-treated blood products as late as 1987, despite the fact that Japan had mandated the use of heat-treated blood products in February of 1986. Of course, even that mandate was far too late. The United States and France had mandated heat-treatment of factor concentrate in October 1984 and October 1985 respectively.²⁵ The delay between the availability of heat-treated blood products and the wide-spread use of such heat-treated products was disastrous for Japanese hemophiliacs.

Another important factor in Japan's case was the economics of insurance compensation. In Japan, the sales of pharmaceuticals to patients are an important supplementary source of income for physicians. In Japan, doctors provide medications to patients, and the government reimburses the physicians for the cost of the medications.²⁶ The rates at which the Japanese government reimburses doctors are controlled by a set fee schedule; doctors may profit from reimbursements if they purchase medications at a discount. Thus, Japanese insurance compensation policies created a financial incentive for physicians who could profit by to over-prescribing imported blood products, which were less expensive than the insurance reimbursement mandated by the fee schedule.²⁷

In the beginning, Japan's Ministry of Health refused to accept responsibility and hid key documents. After a new election put progressive officials in place who were not invested in the implementation of previous blood supply policies, Japan's new health minister worked swiftly and effectively to resolve the crisis. Authorities held a full investigation and filed charges of professional negligence against senior health officials, two of whom were found guilty. As discussed below, Japan also provided an extensive and generous compensation plan for HIV/AIDS victims.

c. France

The history of the blood scandal in France has shades of both the institutional failures of the United States to move quickly in the face of a complex emerging danger and the public-private sector problems of Japan.

At least 1,783 hemophiliacs and as many as 6,000 people in total were directly infected with HIV/AIDS through the French blood supply.²⁸ In the early 1980s, France's blood industry had been nationally controlled for a number of years, and domestic supply was increasingly unable to meet the demand. However, reluctant to import blood from the United States (where the blood supply was known to have a relatively high prevalence of HIV and hepatitis), and unwilling to admit that U.S. scientists had developed better heat-treatment processes, French policymakers chose to focus on building a self-sustaining national blood supply system that would be independent of the international blood markets. These decisions had disastrous consequences.

First, in order to augment the ranks of blood donors, French policymakers chose to include prison populations, a high-risk population from the standpoint of HIV prevalence. Even though blood donations from prisoners never constituted a large percentage of total blood donations, the HIV-positive blood from prisoners was spread widely through the blood fractionation process. Like the United States, French policymakers also acted slowly in excluding men who have sex with men from donation pools.²⁹

Second, France's failure to quickly adopt and mandate the most advanced blood safety technology also

resulted in avoidable HIV/AIDS infections. As with Japan, some French officials were subsequently accused in criminal indictments of having failed to pursue the best available blood-safety technology because of professional animosity and financial considerations.³⁰ As in Japan, ministry officials appear to have delayed the adoption of life-saving technology in order to protect the market share of domestic pharmaceutical firms. And also as with Japan, French companies, researchers and government officials chose to rush to develop their own heat-treatment process instead of adopting U.S. technologies. French officials also continued distributing untreated blood long after doing so was unnecessary.³¹

France commissioned an investigation by Michel Lucas, Inspector General of Health Affairs, who found that “delays in requiring heat treatment of blood stocks to kill the AIDS virus and in adopting a new screening test for blood donors” exposed French citizens to the virus.³²

Charges were brought against senior officials. In 1992, a Paris Court of Appeals found that Michael Garretta, the former Director of the National Blood Transfusion Center (CNTS); Jean-Pierre Allain, the former Scientific Director of CNTS; and Jacque Roux, the former Director General of Health, were all guilty of criminal misconduct for their roles in distributing tainted blood products to French hemophiliacs.³³ Garretta and Allain received four and two year sentences respectively, while Roux’s sentence was suspended.³⁴ The former Prime Minister, Laurent Fabius, as well as the former Health Minister and former Social Affairs Minister, were all cleared of charges of manslaughter in 1999.³⁵

d. Canada

In the early 1980s, a few years after the U.S., Japanese and French HIV blood supply outbreaks, between 900 and 1,400 Canadians became HIV-positive after receiving transmissions of blood products, whole blood and blood components.³⁶ The Canadian Red Cross, which then managed Canada’s blood supply, received a major portion of the blame for the ensuing public scandal.

In Canada, blood-related infections occurred for many of the same reasons as in other countries. Like other countries, Canada was slow to revise blood donation policy in the face of emerging evidence that an epidemic was underway.³⁷ Canada failed to act effectively on advice that would have prevented HIV transmission; the Krever Report later characterized the Canadian Red Cross’ safety measures as “ineffective and half-hearted”.³⁸ Canada also missed the opportunity to avert some of the blood product HIV infections by failing to mandate the testing of blood supplies when other nations had already started to do so aggressively.³⁹ These problems could be partly attributed to Canada not having created a centralized system of active federal regulation of blood collection; instead, responsibility was split between the Canadian provinces.⁴⁰ Canada also used blood and plasma procured from the U.S., especially from prison populations, at a time when health authorities knew that such blood and plasma were high-risk.⁴¹

The Canadian Red Cross was also inexplicably slow to switch to heat-treated blood products. Tragically, the Red Cross continued to distribute untreated plasma even after heat-treatment processes were available, and “distributed more than eleven million units of unheated clotting factor, even though plenty of safe material was on hand”.⁴²

In 1989, the Canadian government offered compensation to victims with hemophilia, but for years, Canadian health officials resisted public calls for an independent investigation.⁴³ However, persistent and organized litigation by victim groups and public outrage over the actions of the Red Cross eventually prompted the Canadian government to launch a thorough investigation. The Canadian government chose Ontario Court of Appeal Justice Horace Krever to lead this investigation. An initial report was released 1995 and the final version was submitted to the House of Commons in 1997.⁴⁴

Justice Krever conducted an extensive and wide-ranging investigation. An important part of his investigation included his determination to hear from victims. He writes,

Early in the Inquiry, I undertook to hear from any person in Canada who had been infected with HIV or with the virus causing hepatitis C as a result of contaminated blood components or blood products, or from members of their families, who wished to relate their experiences to me. Many of these persons were already seriously ill. In order to hear from them and other concerned persons, the first phase of the public hearings was conducted between February and December 1994 in every province except Prince Edward Island, for which evidence was heard in Halifax.

In addition to infected persons or members of their families, those who testified in the first phase of the hearings included employees of local Red Cross blood centers, provincial government officials, and representatives of community and AIDS-related organizations. Three hundred and fifteen witnesses testified during this phase of public hearings.

Michael Orsini, a professor of political science at University of Ottawa, calls this “a very important decision of the inquiry”, and adds,

I think it was tremendously important that these folks were allowed to address him and the Canadian public.⁴⁵

Justice Krever held two additional public hearings. A total of 474 persons spoke at the hearings, and the Commission also gathered eighty-nine written submissions from persons with AIDS and related organizations. In addition, the Commission established a free hotline and received calls from over 300 people around Canada.

The resulting three-volume Krever Commission report, which is perhaps the most comprehensive investigation conducted in any of the countries discussed here, had a dramatic impact. As the damning evidence from the Krever Commission came to light, public condemnation surged. The Canadian Red Cross and pharmaceutical companies sued, taking their case to the Supreme Court in an effort to block Krever’s report, but were ultimately unsuccessful.⁴⁶

As a result of public pressure triggered by the Krever report, Canadian victims infected with hepatitis C, initially the “forgotten victims” of this tragedy, won substantial compensation.⁴⁷ The Canadian Red Cross pled guilty to distributing HIV infected blood in violation of Canadian laws governing food and drugs.⁴⁸ In addition to a \$5000 fine, the Red Cross set aside \$1.2 million to be spent on medical research and scholarships for victims’ children.⁴⁹ The director of the Red Cross, Dr. Roger Perrault, was charged with criminal negligence. The toll on the Canadian Red Cross was significant, and ultimately resulted in the Red Cross wholly leaving the blood business in Canada.

e. Blood Scandals in Other Countries

Although the cases discussed above were among the largest and best-publicized, as Table One shows, the infection of individuals with HIV positive-blood has occurred in almost all other developed countries, as well as many developing ones.

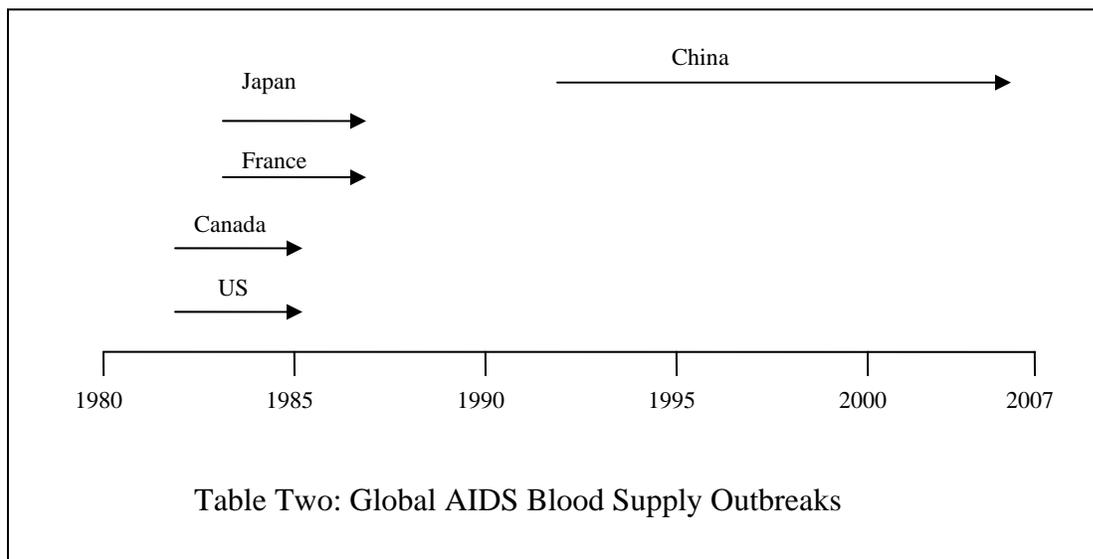
In some developing countries, such as Mexico, blood supply infections resulted when the regulation of blood in more developed countries drove up the global price of blood, spurring the growth of unregulated blood collection systems in which donors were paid to give whole blood or plasma.⁵⁰ In other countries, such as the Netherlands, infections occurred through transfusions of blood products when the government was slow to accept heat-treatment processes.⁵¹

In many developing countries, the regulation of the blood supply continues to be problematic. India has continued to experience outbreaks of HIV in the blood supply in recent years,⁵² and the blood supplies of smaller developing countries such as Kenya continue to be plagued by a high prevalence of HIV/AIDS.⁵³ Furthermore, the transmission of HIV/AIDS through blood transfusions has also recently been the subject of publicity in Kazakhstan⁵⁴ and Libya.⁵⁵

In sum, the accounts above present a less-than-flattering picture of the international community's record on blood safety. In some countries, systemic failures led to infection with HIV through a poorly-regulated blood supply; in others, politics and private economic interests trumped science. From the United States, which failed to appreciate an oncoming disaster and react swiftly, to the Japan and France, whose officials faltered in the face of personal and pecuniary interests, governments have had a poor track record of protecting the health of their blood donors and recipients. In each country, hemophiliacs in particular were left vulnerable in the face of a burgeoning epidemic.

However, faced with these catastrophes, the four countries described above did find national solutions. In that respect, to varying degrees, they may offer useful models for developing countries such as China that are still wrestling with compromised blood supplies. Each of the four countries discussed here held national investigations, established compensation funds, and brought blood regulation under central control.

These measures should be borne in mind as we turn to the substantially more complex situation in China.



III. CHINA'S EXPERIENCE

The economically developed countries discussed above had AIDS blood supply outbreaks of relatively limited scope. The infections generally took place in a clearly demarcated time period. Once they came to light, there was a public outcry, a flood of lawsuits, a government response (usually including an investigation), and ultimately, new central government policies on blood regulation and compensation for victims; though these have not always occurred in the order presented.

The threats to China's blood supply have more complex sources, but that threat continues into the present. The Chinese HIV blood supply outbreak began in the early-mid 1990s, but the pressures that triggered the blood disaster then have not abated today (*See Table Two*). As Ministry of Health officials acknowledge, hospitals and blood banks are still often engaging in risky procedures when collecting blood. China's blood supply continues to be dangerously unsafe.

Compensation to victims has also been unsatisfactory. Without a national compensation fund, local authorities and courts have been left to handle blood transfusion litigation on their own, with uneven results.

Key issues to note in China's crisis are:

- *The Henan precedent.* China's HIV/AIDS blood transmission problem had its roots in the mid-1990s, when rural people from Henan province began to come forward and reveal that villagers across the province had become infected with HIV through blood collection centers. Some centers were run with the involvement of health bureaus, but no official has ever been held accountable. Today, new HIV infections through hospital blood transfusions continue to come to light around the country.
- *Economic pressures fuel the crisis.* Why does China continue to have new HIV infections through blood transfusions? Despite ongoing efforts by the central government to end illegal blood sales, economic pressures continue to fuel this dangerous underground trade. As we have seen in other countries, the pressures of the high demand for blood and blood products create pressures to supply blood from anywhere, anyhow. China faces the additional economic pressures created by its extensive, but under-funded public health system. Chinese hospitals, and especially those in impoverished rural areas, must continually seek ways to supplement their incomes. Expensive blood transfusions can bring a much-needed transfusion of cash to a struggling hospital or small-town clinic. However, the supply of legal blood and blood products is inadequate to meet the demand, and so some local hospitals and clinics reportedly turn to illegal, underground "bloodheads" (brokers) who do not screen donors or test their blood for HIV. In the coming years, China's demand for blood and plasma will only increase, creating a heightened risk to the blood supply.
- *Uneven access to justice across the country.* Seeking compensation and help in paying for rising medical bills, persons infected with HIV through blood transfusions have sued hospitals for compensation in various Chinese provinces. However, while some provinces have allowed cases to proceed, which have yielded relatively high compensation, others are refusing to accept any cases relating to HIV, leaving many without legal recourse. In China, as in other countries already discussed, hemophiliacs have been at the forefront of advocacy for compensation.

Today, even as central health authorities work to develop and implement a coordinated national AIDS outreach and prevention program, cases of HIV infection through hospital blood transfusions continue to come to light.

The Henan Precedent

China's first case of HIV/AIDS was diagnosed in 1985. Because of the high rate of HIV prevalence in the U.S., China's initial response was to assume that the risk to the country was an external one. Early policies focused on preventing foreigners who might have HIV from entering the country.¹ Blood and blood products from the West were also viewed with suspicion.

In the early 1990s, local Chinese health authorities first became aware that the global plasma industry was a lucrative one and with potentially great economic benefits for impoverished rural regions. Health authorities began to establish commercial blood collection centers, and promoted blood selling to cash-strapped farmers.² Most donors were between 20-50 years of age and donated numerous times. Donors typically received about 50-200 yuan (US\$6-25) for each donation.³ Many donors went to several blood collection centers, or used fake names in order to donate more often. Through the blood fractionation and reinjection process described in the beginning of this report, these centers efficiently facilitated the spread of HIV to villages across the Chinese heartland.

Laboring under the belief that foreign blood was dangerous while domestic blood was clean, central health authorities were slow to begin testing of the domestic blood supply.⁴ In the early 1990s, China began to receive warnings from its own health experts and from the WHO about the risk to the blood supply.⁵ Like other countries discussed above, however, China was slow to act on these warnings. It was not until HIV infections through the blood supply began to come to light, in spring 1995, that authorities closed all commercial plasma centers, and began to mandate heat-treatment of plasma.⁶ Even then, though, authorities acknowledged that the safety of China's blood supply was not secured.⁷ Illegal underground blood collection centers have continued to do their work in the countryside, fueled in part by the profit that can be made as a result of the high demand and short supply in the market for blood.

Central authorities have since acknowledged that most of China's provinces suffered from similar problems with HIV infection through blood sales.⁸ However, Henan province has been the focus of international and domestic attention to the epidemic for a number of reasons: the extent of the epidemic there, the province's proximity to journalists and NGOs in Beijing, the provincial government's longstanding denial about the scope of the problem,⁹ and local authorities' sometimes heavy-handed response to local AIDS advocates.¹⁰ As a result, in recent years, certain Henan villages have been selected as targets for government intervention.

The question of the number of people infected with HIV in Henan province and nationwide remains a politically sensitive one, in part because of local authorities' role in the 1990s disaster. Officially, China's Ministry of Health, UNAIDS and CDC jointly estimate there are 650,000 living with HIV/AIDS, of whom 25,036 live in Henan.¹¹ This number is an estimate only, because while China continues to improve and expand its sentinel surveillance testing, the system is not yet far-reaching enough to give a reliable count. However, other experts allege that the real number may be over 1 million people with HIV in China.¹² Activists in Henan have consistently charged that the true number of people living with HIV/AIDS in Henan is far higher than the official estimates.¹ Local resistance in Henan to investigation of the AIDS

¹ In 2000, a widely-cited essay by a Chinese AIDS advocate alleged that a report from Shangqiu county in Henan had found 84% of 100,000 people tested were HIV positive. According to the author, the report had been commissioned by local health officials and was then suppressed. He alleged that a million people had sold blood in Henan (He Aifang, November 28, 2000, "Revealing the Blood Wound of the Spread of HIV/AIDS in Henan Province," <http://www.usembassy-china.org.cn/sandt/henan-hiv.htm>, retrieved July 23, 2007; In 2000, a Chinese researcher from Hubei, working in Henan without official permission, tested 155 farmers from Shangqiu and found that ninety-six were HIV-positive. (Elizabeth Rosenthal, "In Rural China, A Steep Price of Poverty: Dying of AIDS," *New York Times*, October 28, 2000, p. A1); Dr. Gao Yaojie, a prominent HIV/AIDS advocate, has estimated that a million people are living with HIV/AIDS in Henan. She estimates that the actual number of HIV-infected people in Henan caused by the

epidemic has been high since the 1990s, in part because local authorities fear that the stigma surrounding AIDS harms the province's reputation and makes it challenging to attract investment.¹³ In August 2007, Henan police shut down two offices of a nonprofit that assists children affected by AIDS, and prohibited a meeting of thirty support groups for people with HIV/AIDS from around the province.¹⁴

Although for Henan the events of the 1990s are now in the past, the involvement of former local officials and resulting political sensitivities have continued to impede efforts by the central government to address the AIDS epidemic there. Moreover, the absence of official accountability for blood profiteering established a precedent for other Chinese provincial authorities, one that undermines central government efforts to promote blood safety nationwide.

Economic Pressures Fuel the Crisis

Though the first Chinese cases of HIV/AIDS came to light in the 1980s, and central government subsequently encouraged testing for HIV, many provinces did not begin to do so until 1995 or even later.¹⁵ In 1995, a Ministry of Health official explained that one major reason for this reluctance to test was that blood screening was expensive, and

Local officials say they don't have a [AIDS] problem so they don't do it. And, even if you can afford the [materials used for testing], they're hard to find.¹⁶

In the wake of the Henan blood scandal, central authorities began to make greater efforts to regulate blood and blood products. In spring of 1995, the government closed all commercial plasma centers, and began to mandate heat-treatment of plasma.¹⁷ In 1997, the central government enacted regulations that detailed procedures for blood collection, the supervision of the industry, and the punishments for those who violated the law.¹⁸ Authorities also began to promote voluntary blood donation as a safer alternative to the inherently risky sale of blood.¹⁹

By October 1999, the State Council had passed the Blood Donation Law, which mandated testing. However, almost as soon as the law was enacted, experts within China began raising concerns about the obstacles to enforcement of the law in rural regions, where lucrative incomes could still be made from the underground blood trade.²⁰

While significant progress has been made towards enforcement of blood supply regulations since the 1990s, there continue to be problems. Central authorities have launched periodic crackdowns and national campaigns for blood safety. The crackdowns have included destruction of HIV-positive blood stockpiles, dozens of arrests and the closures of hundreds of blood collection stations.²¹ Authorities have joined forces with the Red Cross to promote a national program of blood donations.²²

Yet progress has been slow. In 2000, five years after the state began to take steps towards ensuring safety of its blood supply, China's then-Minister of Health, Zhang Wenkang, acknowledged that China "still has a long way to go to guarantee blood safety."²³ Seven years later, in June 2007, the Ministry of Health announced that "the phenomenon in some areas of paying for blood supplies, or making money from blood, still exists, and there are hidden dangers for blood safety."²⁴

Periodic press reports have revealed illegal operations in which "bloodheads" bused people in from other towns in order to sell their blood illegally.²⁵ Worse, as Ministry of Health spokesman Mao Quan'an

blood scandal may be 10 times higher than the official number. (Bates Gill, Yanzhong Huang, and Xiaoqing Lu, *Demography of HIV/AIDS in China*, p. 29).

observed to a reporter in 2004, hospitals and health clinics have also engaged in the illegal blood trade:

Attracted by high profits, some official blood centers and even hospitals have also been collecting blood improperly...For example, they collect blood too frequently from too many people whose livelihoods depend on selling their blood. Also, laboratory testing, if conducted at all, was often poorly done. Some blood banks have bought blood without regard to standards.²⁶

Health officials estimate that, despite frequent government crackdowns on illegal blood sales, up to 20 percent of the clinical blood supply continues to depend on paid blood sales.²⁷

Unsurprisingly, then, numbers of HIV infection through blood transfusion continues to be high. According to a UNAIDS, Ministry of Health and CDC joint report,

Approximately 69,000 former commercial blood and plasma donors and recipients of blood or blood products through transfusions, are living with HIV/AIDS, **accounting for 10.7% of the total number of estimated HIV cases.** Five provinces--Henan, Hubei, Anhui, Hebei, and Shanxi--account for 80.4% of infections in this population [*emphasis added*].²⁸

Many of those infected are women and children. In some of the most prominent cases, women have been infected with HIV while giving birth, and have then infected their children through mother-to-child transmission.² AIDS advocate Wan Yanhai argues that a significant portion of these cases affect women and children.

Most recently, China has announced stricter controls over illegal blood collection, including plans to revoke the licenses of blood collection centers found in violation of the law.²⁹ In some areas, there may even be video monitoring of blood collection work.³⁰

These steps are welcome, but even more sweeping actions may be required to face the challenges of the future. A 2006-07 China blood products industry report forecasts that China may become one of the world's major biopharmaceutical markets in the next twenty years.³¹ As the market demand continues to grow at a rate of fifteen percent annually, the price of plasma is expected to continue to rise in 2007-08, creating additional pressures on hospitals as well as incentives to bloodheads to rapidly grow the underground trade in blood.³²

Uneven Access to Justice

Statistics are not yet available on the number of AIDS blood transmission lawsuits around the country.³³ However, there have been a number of such cases in provinces around the country, notably in Henan, Hebei, Jilin, Heilongjiang, and Shanghai.³⁴ As in other countries, Chinese hemophiliacs have been among the most vulnerable to infection, and are in the vanguard of the grassroots effort to litigate for compensation.

However, such litigation has had mixed results. In some regions, courts are refusing to open the doors to any cases relating to HIV/AIDS infection. The Korekata AIDS Law Center attempted to file a case on HIV infection of a child through a hospital blood transfusion in Henan province, and was informed by the court that because the national government has established the "Four Free, One Care" program to provide free

² Two of the best-known cases are that of Wang Weijun, whose wife was given a blood transfusion while giving birth to their child (Case narrative on record with Asia Catalyst), and Li Xige, who was given a blood transfusion by an illegal blood-seller while giving birth to her daughter (Li Xige, *Open letter to Hu Jintao, President of People's Republic of China*, August 13, 2007)

antiretroviral treatment and small living stipends to people with HIV/AIDS, Henan courts had been instructed not to hear any cases involving HIV/AIDS [*For summary of the Four Free, One Care program, see Appendix*].³⁵ An AIDS lawyer notes that this has been a trend in some regions.³⁶ AIDS advocate Li Xige reports that she and others infected with HIV by the same Henan hospital were refused the right to file suit and were promised that local authorities would see that they were awarded compensation, but says that compensation has not been paid. In an open letter to the president of the People's Republic of China, she writes,

Over the past three years, the Ningling county court has continually refused to hear the case, and the government has also not resolved the compensation issue. It is now three years since my eldest daughter's death [from AIDS]. When I look at my youngest daughter, the image of her sister who passed away, I feel like dying. Where is justice?³⁷

Henan is not the only province to refuse to hear AIDS cases. In Jiangsu, a group of blood transfusion litigants were informed by the court that a circular had instructed them not to hear any AIDS-related cases because the government is already providing compensation to people with HIV/AIDS.³⁸

As AIDS advocate Li Dan points out,

The problem with the "Four Free, One Care" policy is that it does not distinguish between ways that HIV was contracted. With children, it is relatively easy to prove that there was no high-risk behavior that would have exposed them to HIV/AIDS, and the hospital should accept responsibility.³⁹

Even in provinces where litigants are able to file suit, they face substantial obstacles to litigation, discussed further in the legal analysis below. In those relatively rare cases where patients are able to gain a hearing in court and triumph over the other legal obstacles to obtain a decision in their favor, compensation amounts awarded by courts vary greatly from one region to another:

- In Xingtai county, Hebei province, where dozens of people were infected by the same hospital, some litigants have won small amounts; in one case, a litigant won 400,000 RMB [about US\$50,000] in a lump sum payment.⁴⁰
- In Inner Mongolia, patients infected with HIV through blood transfusions have won compensation in the amount of 300 RMB [about US\$40] per month for each adult, 200 RMB [about US\$26] per month for each child, as well as additional support and counseling.⁴¹
- In Shanghai, the court awarded hemophiliacs infected with HIV through blood products a one-time payment of 100,000 RMB [US\$13,219], as well as 1000 RMB [about US\$132] per month per person, and support for some medical expenses.⁴²
- In Hubei, Xiangfan City has promised to award persons infected with HIV through blood transfusions between 100,000-200,000 RMB [US\$13,219-26,437] each.⁴³
- In Heilongjiang, in the largest collective lawsuit to date, nineteen people with HIV/AIDS won lump sum payments of US\$25,500 per person, plus monthly payments of US\$382 each, and assistance with some medical expenses. Each family of two patients who died will receive US\$45,000 each.⁴⁴

Many cases never reach this stage, however, because, hospitals and litigants reach settlements out of court. Typically, these amounts have been lower. For instance, in Jilin, a group of sixty-eight people reached a settlement with a hospital they claimed infected them with the AIDS virus of 40,000 RMB [US\$5,287] per person.

Hemophiliacs and the Shanghai Bioproducts Research Institute

China has approximately 130,000 hemophiliacs.⁴⁵ Because of the reliance of hemophiliacs on blood products for their survival, they early on became some of the first victims of HIV-positive blood supplies. In the late 1980s, four hemophiliacs in Zhejiang became infected with HIV after receiving transfusions of blood clotting factor VIII, and all four died of AIDS.⁴⁶ In the 1990s, because China had banned imports of blood and blood products from other countries, hemophiliacs relied on domestically-produced clotting factor VIII, some of which was infected with HIV through blood and plasma donors in the central provinces.

Today, Kong Delin, Deputy Director of the Shanghai-based Hemophilia Home of China, estimates that more than 1,000 hemophiliacs are HIV-positive as a result of infection through blood products.⁴⁷

In 1998, sixty-four hemophiliacs in the Shanghai region were infected with HIV after receiving transmissions of clotting factor VIII produced by the Shanghai Bioproducts Research Institute. According to Wan Yanhai,

The Shanghai Bioproducts Research Institute was run by the Ministry of Health. They should have used their expertise on AIDS to prevent the spread of HIV, or at least warn hemophiliacs of the potential danger from transfusions.⁴⁸

Four of the Shanghai hemophiliacs have since died of complications relating to AIDS, while some others have unknowingly infected their children through mother-to-child transmission.

Since 2000, this group of hemophiliacs has attempted to obtain compensation from Shanghai Bioproducts Research Institute. Initially, courts refused to hear their cases,⁴⁹ and both the company and municipal health officials have continually denied any responsibility. As Wang Panshi, Director of the Division of Health Inspection at the Shanghai Municipal Health Bureau, told a reporter:

There is no direct relation between the fact that hemophilia patients were contaminated with AIDS and the fact that the patients have ever used a medicine product by the company. If I went out and got a cold, who will shoulder the responsibility for my cold?⁵⁰

In 2002, a Shanghai court ordered the establishment of a compensation fund for the Shanghai hemophiliacs. However, Shanghai Bioproducts Research Institute was still not held responsible, and the compensation fund only applied to hemophiliacs living within Shanghai city proper.

Meanwhile, hemophiliacs in other provinces have continued to step forward and allege that they, too, were infected with HIV as a result of treatment with Factor VIII produced by Shanghai Bioproducts Research Institute. Suits have been filed against the company in Hunan, Liaoning, Jilin, and Heilongjiang provinces.⁵¹

IV. LEGAL ISSUES

While sharing many commonalities, in certain respects, China's experience is quite different from that of the other countries discussed above. For one, China has a significantly larger and more impoverished population than the U.S., Japan, France or Canada. China is also still developing its legal system. As a single-party state, China's system also presents specific challenges. For instance, while elections in Japan created an opening for new leaders to radically change blood supply-AIDS compensation policy, such changes are unlikely to take place in China.

Nonetheless, all the countries discussed here, in varying ways, acted forcefully and effectively to contain, address, and compensate victims of their AIDS blood supply outbreaks in ways that may be replicable, in altered form, in a Chinese context. In addition, international experience is partly codified in international laws. All members of the United Nations and States parties to international human rights treaties share common obligations. These laws are drafted by experts familiar with the international experience with such problems as HIV/AIDS and the right to health, and thus they also provide a useful guide to Chinese policy development.

Right to Health

International law guarantees everyone the right to the highest available standards of health—a right that should include the highest available standards of blood safety. According to the **Universal Declaration of Human Rights** (UDHR), everyone is entitled to “a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services.”¹

In addition to the UDHR, two major treaties are fundamental to international human rights law: the **International Covenant on Economic, Social and Cultural Rights** (ICESCR) and the **International Covenant on Civil and Political Rights** (ICCPR). China has signed and ratified the ICESCR, which commits the Chinese state to the progressive realization—or, the realization over time—of the right to health. According to the ICESCR, in order to engage in “progressive realization,” States parties to the covenant must be taking steps necessary for “the improvement of all aspects of environmental and industrial hygiene” including “the prevention, treatment and control of epidemic, endemic, occupational and other diseases.”² Thus, the state must have a plan to bring its facilities up to the highest available standard and be taking steps forward with that plan.

In interpreting the right to health, the Committee on Economic, Social and Cultural Rights acknowledged that the precise nature of health facilities available in any given country will vary depending on a given state’s level of economic development. However, States parties must guarantee

the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs.³

Providing such fundamental facilities to Chinese citizens as adequate health facilities includes taking all possible steps to ensure that blood or blood products provided in those facilities meet the highest available standards in China. Thus, blood transfusions in rural clinics and hospitals—facilities in places like Heilongjiang or Hebei—should meet the same high standards as blood transfusions in any developed city in the country.

The Committee’s interpretation also provides for the “progressive realization” of the right to health over a period of time. This means that while States parties may not be able to fully realize the conditions to ensure the right to health, they still “have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization” of that right.⁴

China’s *Blood Station Management Law* (血站管理办法) and the *AIDS Prevention Act* (艾滋病防治条例) do outline clear standards that blood collection stations must meet in their collection of blood donations, and that hospitals and clinics must meet in their testing and handling of the blood supply.⁵ The problem has largely been implementation. Blood collection stations are overseen by a

multitude of national and local agencies, and it is not clear if any central facility tracks each blood donation or accredits all blood stations.⁶ Creating a plan that would move the blood supply toward a more centralized and efficient system of control would help to avoid contamination of the supply, and would also make it more difficult for cash-strapped hospitals to introduce illegally purchased blood into the system. **Asia Catalyst recommends that the WHO, governments and experienced nongovernmental organizations in the U.S., Canada, Japan and France expand or initiate technical assistance programs that will help China to establish a more centralized blood safety system.**

National Investigations

All the countries discussed here commanded independent entities to conduct national investigations into their blood supply disasters. Perhaps the model for these investigations was the Canadian Krever Commission, headed by Justice Horace Krever. The commission thoroughly investigated the role of the government and the Canadian Red Cross, invited victims and experts to testify, compelled pharmaceutical companies to testify, and surveyed the experience of other countries.

After these investigations were concluded, Japan, France and Canada successfully used criminal prosecutions against responsible health officials as a way to deter the risky and illegal behavior that tends to spread HIV through the blood supply. Criminal charges also created a norm that holds those responsible for formulating and implementing blood policy to a high standard.

In China, where the AIDS blood transmission outbreak in some provinces dwarfs those of Japan and France by several orders of magnitude, health officials who acted negligently or criminally while directly profiting from the causes of the blood scandal have rarely been held personally accountable.

The sole Chinese instance of official accountability in this regard is Inner Mongolia, a province with a relatively low HIV prevalence. In 2005, a court sentenced two county-level Inner Mongolian health officials to three-year prison sentences each for transmitting HIV to eleven people through blood collection schemes.⁷

In an ideal world, China could also hold a high-level, independent investigation into the country's blood supply problems, determine official responsibility, and make recommendations for the establishment of a compensation fund.

Realistically, however, given the political sensitivity of the issue, it is impossible to identify any entity in China that would be able to conduct such a public investigation without political influence or repercussions to those involved. While an independent commission conducting an investigation and public testimony by people with HIV/AIDS would be a valuable and important precedent in China, it is not necessary to the accomplishment of the more urgent tasks of improving control of the blood supply, and compensating as many victims as possible, as soon as possible.

Access to Justice

Under international law, states must ensure that victims of serious human rights violations have the right to remedy those wrongs. States are also required to provide reparations to the victims. Even if the personnel who are currently in office were not responsible for the rights violations personally, they must still fulfill the obligations of their predecessors.

The UDHR guarantees a right to remedy for violations of rights protected by “the constitution or the law.”⁸ The Committee for Economic, Social and Cultural Rights has also reaffirmed and elaborated on the right to remedy for victims of violations of the right to health:

Any person or group victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels. All victims of such violations should be entitled to adequate reparation, which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition.⁹

Of importance to the situation in China, where some provinces have refused to hear cases of HIV transmission through blood transfusion while others have awarded high compensation packages, is that judicial remedies must be equally available to and enforceable by all citizens of the state. They cannot be offered only to residents of certain regions, and denied to residents of other regions.¹⁰

Expanding universal access to justice is an important part of developing a functional legal system. If a victim chooses not to accept moneys from the national compensation fund, she or he should still have the right to bring a lawsuit and have it duly processed. Moreover, while a compensation fund might release the government from liability, private actors should be subject to law suits under Chinese law. **Asia Catalyst recommends that the Chinese Ministry of Justice issue a circular that will immediately order all courts to accept lawsuits on HIV transmission through blood transfusions.**

Problems with Litigation

Opening the courts will be important in the short term, but in the long term, given the obstacles described below, it may not provide a satisfying solution. Actual litigation results have varied from country to country.

Most of the contaminated blood cases discussed above followed similar trajectories. As is still the case in many places today, HIV/AIDS carries a stigma and the threat of discrimination; persons with HIV are often reluctant to come forward for fear of losing their jobs, homes, and access to education for their children. Thus, due to both the latency period of the virus and hesitation of victims to reveal their identities, most HIV-blood disasters came to light slowly. Gradually, as a few pioneering individuals bravely filed lawsuits, fear gave way to anger. As anger mounted and individual cases piled up, solidarity movements emerged, and people living with blood supply-related HIV/AIDS began filing collective legal actions.¹

What began as a trickle of law suits soon became a torrent. In the United States, between 300¹¹ and 500¹² cases were ultimately filed by the mid-1990s. In France about 2000 individual suits were filed.¹³ Whereas litigation in the United States yielded little in actual adjudicated damages rewards,² litigation in France and particularly Japan yielded large recoveries and negotiated settlements.³

While China's legal system is unique in some respects, Chinese litigants have encountered some problems

¹ The movement from individual to collective suits occurred in the United States as well as France to some extent partly as a result of the high costs that plaintiffs and court systems faced in adjudicating suits individually. The benefit of not having to subject a victim to what was then a much more stigmatizing public admission of HIV/AIDS status might have also been a factor. While collective suits are certainly more efficient, they also raise the stakes of litigation dramatically basing the fate of many on the decision of one court. In the United States, a federal appellate court actually disallowed a group of HIV-infected hemophiliacs from proceeding in a class action suit because suit constituted too weighty a decision to be decided by one set of jurors. Judge Posner, the presiding judge, also reasoned that the potential liability of the industry was so large as to endanger it with bankruptcy or unduly coerce to settlement. Feldman & Bayer, *Blood Feuds*, 49.

² Prior to 1993, American courts almost never held for plaintiffs and after 1993 only did so rarely. 1993 was the year in which courts started sending the cases to juries to weigh issues of reasonableness. Feldman, "Blood Justice," 673.

³ In the United States, it is easy to distinguish between a court settlement and legislative compensation. In Japan and France, it is not as clear whether the ultimate recoveries against the governments were court settlements, legislative rewards or something in between. That determination is not important for this paper. It is important that in France and Japan large legal actions greatly increased public outrage and pressured the government to act.

common to those of litigants in other countries, and exploring these further may help to explain why ultimately many countries opted not to rely on the court system but instead to establish national compensation funds. These problems include

- problems with evidence and the discovery process,
- the challenge of establishing legal causation,
- debates over the legal characterization of blood, and
- the amount of time it can take to win a lawsuit and enforce a judgment.

Problems with evidence and discovery: A plaintiff's entitlement to discovery varies from one country to the next. In cases where plaintiffs must prove HIV transmission occurred through the actions or inactions of a specific health care facility, the ability to access evidence is obviously crucial to the success of the lawsuit. However, the responsibility of state and non-state actors within a given country to provide internal information to a court can vary.

One reason that suits against private actors were largely unsuccessful in the United States is that some courts refused to grant discovery motions against defendants.⁴ To succeed in court, plaintiffs needed information about blood donors, donation procedures, the use of medical technology, and how blood products were inventoried; the inability to gather this information often left plaintiffs with weak cases. In contrast, when plaintiffs won legal battles over discovery requests in other nations, most prominently Japan and the United Kingdom, defendants often capitulated almost immediately.

In China, patients have largely been unable to compel hospitals to share their files, and so they often run into problems with lack of evidence. Patients also sometimes find that they have failed to retain documentation of their hospital stays. Hospitals may also refuse to acknowledge that the patient was ever actually a patient at their hospital, or deny responsibility for the infection. In the case of Wang Weijun, whose wife was infected with HIV by a Hebei hospital, the hospital claimed that she had never been a patient there and alleged that she had had relations with other men.¹⁴ In another well-publicized case, a nine-year-old boy lost a suit against the hospital his family claimed infected him with the AIDS virus due to lack of evidence, though the boy's age made it extremely unlikely he was infected any other way.¹⁵

According to Wan Yanhai, the problem is a common one:

Clinical files disappear, and most patients don't know that they should keep a copy of the files themselves. Most transfusion victims are women and children, especially because hospitals often give blood transfusions during or after labor or abortions. Many of these cases are hard to prove.¹⁶

However, Wan notes, if the hospital took money from the patient for a blood transfusion, then the hospital should have a record of this income in its accounting department, and in lawyers might look to these records as evidence of hospital responsibility.

Problems with establishing legal causation: This question has manifested itself in two forms: 1) whether a plaintiff could establish that one specific actor versus another caused HIV transmission, and 2) whether it could be established that any actions or omissions in the then-existing information environment caused HIV

⁴ It is worth highlighting that the inaccessibility of extensive discovery in the United States was not necessarily motivated solely by defendant-friendly judges. In the healthcare context, stringent regulations control the flow of personal information and it is personal information—particularly about donors—that is possibly the most valuable information in blood litigation. These regulations operate partly as a function of civil liberty concerns and privacy interests.

infections. These questions were of critical importance in the 1980s and 1990s, when scientists were still learning about HIV and how it is transmitted. The question of emerging science and responses to uncertainty is not directly implicated in the analysis of China;⁵ by the time the AIDS blood supply outbreak occurred in China, the HIV virus and its risk factors were well-understood by international science, if not always by local actors.

In blood litigation, problems of causation also often hinged on whether it could be established that a certain hemophiliac had received HIV-positive blood products from one company versus another. Ultimately, courts in Japan and France did not have to grapple with this type of issue, because all the blood product producers were found to have acted negligently. In the United States, causation issues were obstacles in the initial wave of single plaintiff cases, but were less problematic in the later collective suits.

In China, where a range of different “bloodheads” operated, often illegally, it will be challenging in many cases to obtain records that could prove which donor and/or recipient was affected by which “bloodhead.”

The legal characterization of blood: The legal characterization of blood has been an important element in the outcome of blood litigation. In the United States, blood was historically considered to be something other than a traditional product or commercial “good.” This notion, codified in various state “blood shield” laws over many years, was driven by the idea that for moral as well as practical reasons blood should not be commoditized. Treating blood as a commodity was thought to be dehumanizing in that it implicitly created the sale of a human part. Practically speaking, if blood was treated as a commodity, it would be subject to market forces which could greatly decrease its supply and in doing so, greatly harm those who depended for their life and well-being on a consistent blood supply.

Of course, the market force which could have the greatest impact on the supply of blood was the imposition of product liability. In the United States, products are generally subject to strict liability, which means that those harmed by products may generally sue for damages and often succeed in recovering damages even if the producer did not act unreasonably or otherwise negligently. Under a regime of strict liability, blood producers would have been held liable for harms that resulted from the use of their blood products even if it was impossible given the current state of scientific knowledge for producers to have anticipated those harms. Such a state of affairs was thought to present a risk of crushing liability which could drive many of the blood producers from the market and in doing so both increase the price and decrease the supply of blood. Blood shield laws prevented strict liability—and for some time, effectively all liability—by simply classifying blood as something other than a commercial product. Without being able to sue based on strict product liability, victims in the United States had to prove that producers acted negligently, a task was nearly impossible given the uncertainty over the science of blood and the fact that most blood producers acted similarly.

This notion of blood as a product was reasonable when relatively little was known about blood, and when there was an accordingly reasonable argument that unforeseeable and unavoidable harms in the blood supply could create enough liability to prevent the blood industry from producing enough blood for those

⁵ For example, in the United States, there were questions about how to determine what the appropriate standard of care was in tainted-blood cases. The standard of care is the legal duty that American society expects its members to act in conformity with. For the medical field, the standard of care has always been determined in light of what a reasonable medical practitioner would have done in a similar situation. When courts faced tainted blood claims in the early and mid-1980s they were faced with a situation in which plaintiffs were claiming that the whole industry violated a duty of care and was accordingly negligent. The scientific uncertainty concerning blood-borne viruses and the necessity of maintaining the blood product supply suggested against holding the whole industry negligent. This type of question should not arise in the context of discussions about blood practices in China post-1995, as scientists now know how to safeguard international blood supplies and blood donation practices.

who needed it. By the time litigants were lining up to sue over HIV-contaminated blood in the United States, however, these laws had become somewhat antiquated and were no longer truly representative of prevailing scientific knowledge. Gradually, courts viewed blood shield laws a little less favorably, by allowing suits to proceed and refusing to dismiss them purely on the basis of the blood shield laws. Nevertheless, these laws were an imposing impediment to American litigants. In Japan, where blood has always been considered a pharmaceutical product, courts were much more receptive to blood-related lawsuits. The question of how blood is characterized in China is still unclear. It could become an important one in future litigation.

Length of time between opening a case and collecting compensation: In other countries, litigants have found that filing lawsuits for compensation is a slow, painful process; in some cases, litigants have died of AIDS before winning compensation. Courts and governments have also found litigation to be costly and consuming of national resources.

Even in cases where patients are successful in their lawsuits, they may face insurmountable obstacles to collecting the compensation. Wang Weijun, whose wife and daughter were infected with HIV through a blood transfusion, pursued justice through the court system for years and was finally awarded 360,000 RMB [US\$47,587]. To date, he has collected only about one-third of this amount.¹⁷

Not only is litigation a draining experience, but many HIV-blood victims in other countries have lost substantial portions of their rewards to lawyers' fees. This was particularly true in the United States, where a federal judge actually prevented a group of class action plaintiffs from firing their attorneys when the plaintiffs claimed that the lawyers were not representing their intentions, but were in fact only pursuing their contingent fees.

Another glaring problem with litigation is that it was far too slow to help many of the plaintiffs. In the 1980s and 1990s, with the limited availability of life-saving medications in the West and in Japan, many plaintiffs died before their lengthy trials rendered verdicts. In one of the few early successful single plaintiff HIV-blood cases in the United States, the plaintiff famously died on the morning that the jury awarded her \$8.1 million in damages.¹⁸

For all these reasons, litigation is often unsatisfactory as a means to resolve a national blood supply catastrophe. Because of the generally unsatisfying results of litigation for victims, and because of the burden that a torrent of lawsuits can create for courts and government, most countries have ultimately decided to create a national compensation fund as a mechanism for responding to the suffering and providing for the needs of victims of tainted blood supplies. In exchange for receiving compensation from these funds, victims have signed agreements pledging not to file lawsuits.

In recent years, the national system of courts in China has undergone a period of formative change. Not only has the judiciary matured of its own right, but national legislation has been enacted to provide better and more clearly delineated access to the courts. Now that China has opened the door to blood suits by allowing a few rural cases to proceed, the precedent is set for future cases. Nevertheless, large-scale litigation seems both unlikely and unattractive. Rather, both victims and government defendants would be best suited by the legislative creation of a compensation fund. While the Chinese government seems inclined to consider such a remedy, the scale of China's blood supply problems counsels against anything less than a comprehensive plan.

V. COMPENSATION

Most governments and industry groups were initially reluctant to accept responsibility for their role in blood supply contamination. However, in each of the four countries discussed here, as trials in most countries drew on and as investigations proceeded, evidence of governmental failure and corruption began to mount. Even then, while litigation did unearth new evidence and stir public passions, it nonetheless turned out to be a generally unsatisfactory mechanism for compensating victims.

Ultimately, countries began to create compensation funds through legislation. First and foremost, such funds were urgently needed by newly HIV-positive persons who faced mounting medical bills.

Second, establishing compensation funds became a way for governments to accept responsibility for their past failures and offer a symbolic act of contrition. While some countries had previously offered humanitarian payments and general medical assistance to infected hemophiliacs and transfusion recipients, compensation funds, titled and understood as such, conveyed an implicit message of public accountability.

Third, governments began to create compensation funds as a means to impose some order and predictability on what was otherwise becoming a vast body of legal claims. Rather than fight out a multitude of suits in courts and risk endless liability, defendant governments and corporations chose to offer compensation schemes as an exclusive remedy. In other words, in order to access a compensation fund, a victim agreed to give up the right to sue in the future. This allowed pharmaceutical companies to avoid bankruptcies, and allowed governments to forecast and contain future expenditures.

The compensation plans were arranged as follows:

Japan: A generous compensation scheme was created by Japan in 1993. This program provided **monthly stipends** of US\$318 to hemophiliacs who were hospitalized due to an AIDS-related illness, in addition to a monthly payment of US\$2,328 to all adult hemophiliacs with HIV.¹

Japan also provided **death benefits**. Monthly payments of \$1,575 were provided for ten years to families that lost primary wage-earners. Upon the death of a non-primary wage earner, families received lump sum payments of US\$63,257, as well as a lump sum payment of US\$1,352 for **funeral expenses**.²

While these payments were not at first extended to **secondary infections** (i.e., spouses who were infected by hemophiliac blood product users), the scheme was amended in 1994 to include payments to spouses.³ This compensation fund was jointly funded by the Japanese government and pharmaceutical companies.

Canada: Canada also provided an extensive compensation program for the victims of HIV-tainted blood supplies. Payments from the national government began in 1988, with **lump sum tax-free payments** of about \$120,000 per person.⁴ The various provinces also provided additional funds for annual payments of up to \$30,000 and death expenses of up to \$50,000. They also provided free antiretrovirals and **funded post-secondary educational expenses for affected children** and caregivers.⁵

France: The amount of compensation paid to individuals infected through blood products and whole blood transfusions was increased numerous times and changed frequently over the years. There were also different funds providing support.

By 1989, the French government was providing **lump sum payments** of between \$5,298 and \$30,088 to anyone infected through blood products. At the same time, the Public Solidarity Fund--a fund created

specifically for infected hemophiliacs and their families and funded by insurance companies--was distributing "\$5,128 and \$29,052 depending on severity of illness, the age of patient, the loss of income, and familial responsibilities."⁶

Due to the high cost of medical bills and the furor over the French scandal, these payments were increased to cover more of the medical bills of victims. When information emerged indicating that the National Transfusion Center had knowingly distributed potentially contaminated blood products, France faced a potential multitude lawsuits. A new fund was then created and funded to provide additional **lump sum payments** of up to \$417,377 per victim.⁷

Germany: Germany's scheme, which was largely funded by pharmaceutical insurers, provided a maximum **lump sum payment** of \$367,724 to each person infected, as well as **compensation to spouses** and compensation for **funeral expenses**.⁸

Australia: Other countries have provided funds for AIDS blood transmission victims, but have refused to identify these funds as compensation. Australia, for example, provided such financial assistance to individuals infected between 1979 and 1985 and their families.⁹ Eligible persons received **annual stipends** of between \$866 and \$6,935 per year. The program began in 1990 and had 353 registrants by 1992. Because the award was so small, and because eligibility for receipt of the funds was not contingent on waiving the right to sue, many Australians eventually also took their claims to court.¹⁰

United States: For many years, the United States, the first country to face a blood scandal, remained the only large, developed country to have failed to establish a compensation fund.

In March of 1995, the United States House of Representatives introduced the Ricky Ray Hemophilia Relief Fund Act, which authorized government compensation to hemophiliacs who had been infected with HIV/AIDS between 1980 and 1987, as well as their survivors, and infected family members.¹¹ The payment was a **lump sum** of \$125,000, and was contingent on an agreement not to sue the Food and Drug Administration. The bill was not fully funded until 2000.

However, disturbingly, the U.S. has yet to establish a compensation fund for non-hemophiliacs infected with HIV through the U.S. blood supply. The U.S. is thus unfortunately not a model for other countries wrestling with the question of how to compensate victims.

However, international law does again provide some guidelines. The *Basic Principles and Guidelines on the Right to Reparation for Victims of Gross Violations of Human Rights and Humanitarian Law* (Basic Principles and Guidelines) reaffirms and elaborates on the legal obligation of states to provide reparations for human rights abuses.¹²

What should reparations include? The Basic Principles and Guidelines includes an extensive list, including restitution, compensation, rehabilitation, satisfaction, and guarantees of non-repetition. Compensation can include compensation for:

- (a) Physical or mental harm;
- (b) Lost opportunities, including employment, education and social benefits;
- (c) Material damages and loss of earnings, including loss of earning potential;
- (d) Moral damage;

(e) Costs required for legal or expert assistance, medicine and medical services, and psychological and social services.¹³

“Rehabilitation” should include medical and psychological services.¹⁴ “Satisfaction” can include such measures as public disclosure of the truth (provided that such disclosure does not further harm the victim or the victim’s family), a public apology, and commemorations and tributes to the victims.¹⁵

Thus, China’s “Four Free, One Care” policy, which provides access to antiretroviral treatment and other benefits to all people living with HIV/AIDS in China without distinguishing those infected with HIV through the actions of state actors, is not a substitute for compensation. Hemophiliacs and other patients infected with HIV through blood and blood products provided by hospitals have suffered physical and emotional pain and suffering caused directly by those hospitals and clinics. They are entitled to reparations for these violations of their rights.

On the whole, Japan’s compensation plan seems to offer the best model. It not only provided generous monthly stipends that supported a person living with HIV/AIDS over an extended period of time, but also provided for the support of the family once a wage-earner passed away. In addition, paying for funeral expenses can be an important source of relief to families struggling under the burden of high medical costs. **Asia Catalyst recommends that China establish a national compensation fund for people infected with HIV through hospital blood transfusions that provides:**

- **a monthly stipend,**
- **support for families once a wage-earner passes away due to complications related to AIDS,**
- **payment for funeral expenses,**
- **psychological counseling,**
- **and a fund to assist affected families with educational costs.**

VI. THE ROLE OF GRASSROOTS NGOS

The compensation funds and government responses discussed in this paper did not emerge in a vacuum. While different cultural contexts influenced government responses, in every country, grassroots nongovernmental organizations, especially organizations representing people living with HIV/AIDS and hemophiliacs, played an important role in educating the public about the problem, organizing litigation, and leading advocacy with the government.¹ However, unity and solidarity between different groups of people infected through the contaminated blood supply affected their success.

In Japan and France, where different groups worked together to generate widespread public outrage about the blood scandals, nongovernmental organizations were most successful.² In Japan, this public outrage even influenced national elections, and gave new political leaders an opportunity to address the problems caused by their predecessors, while enhancing their own progressive credentials.¹ In the U.S., though, where hemophiliacs split from other AIDS groups and even fought amongst themselves, compensation took many more years to come through. In the end, the U.S. awarded compensation to hemophiliacs but not to

¹ When a new Japanese Prime Minister from a resurgent political party was elected in 1995, he appointed a new and progressive Minister of Health and Welfare who moved quickly in finding allegedly lost documents and complying with discovery requests. These documents made inevitable later resignations and acknowledgement of guilt, and paved the way for the creation of a more robust compensation scheme. Feldman, “Blood Justice,” 681.

others.

In all four countries—the U.S., Japan, France and Canada—hemophilia organizations have played a leading role in driving advocacy efforts. In the early stages of the AIDS epidemic, a large number of non-hemophiliacs were infected through blood transfusions. Although some non-hemophiliac whole blood transfusion recipients successfully brought lawsuits, they did not generate as much public outrage and sympathy as did the hemophiliac groups. This public outrage influenced how courts and governments addressed claims by victims for compensation and justice.

In many ways, hemophiliac organizations were well-positioned to take a leadership role because they already had strong membership-based organizations. Prior to the contaminated blood supply tragedies, hemophiliac organizations focused their work on servicing the needs of hemophiliacs by providing them with health information and by lobbying for the interests of their membership.³ When the problem of HIV transmission through transfusions started to emerge, the hemophiliac organizations already had a strong membership base. They were ready and able to organize their members and to give them a voice. As David Kirp notes

As the toll of blood-linked AIDS deaths mounted, both among people exposed to the virus through transfusions as well as hemophiliacs, levels of anger rose. Whether this anger became a precursor to collective action...depended on whether or not these individuals were able to mobilize. Hemophiliacs mobilized.⁴

Why did non-hemophiliacs take more time to mobilize? Kirp argues,

People infected while receiving HIV-contaminated blood transfusions were widely diffused among the population. They represented a near-random sample of their nations' citizenry, with no history of being oppressed by their condition and no organization to which they could turn.⁵

In the United States, these hemophiliac groups were able to prod the government to commission an investigation by the Institute of Medicine. In Japan and France, hemophiliac organizations instigated and maintained public outrage by tirelessly working to keep reports about the scandal appearing in the media.

However, in the U.S., groups splintered and engaged in sometimes counter-productive infighting. The executive director of the National Hemophilia Foundation (NHF) initially opposed the creation of a compensation program which would exclusively compensate hemophiliacs. As Bayer and Feldman note,

As early as 1988, the executive director of the NHF made clear his opposition to such a scheme...First, he asserted that in the absence of a strong welfare state ideology in the United States, it was unlikely that the notion of compensation would have much support. Second, he doubted that the Congress would be willing to establish the precedent for providing compensation for other groups that might be afflicted by iatrogenic injury. Third, an effort to obtain compensation would conflict with the more pressing agenda of obtaining government support for paying for safer but ever more expensive clotting factor. Fourth, and most arresting, he argued that an effort to obtain compensation for those infected through the blood supply would be dangerously divisive, separating "innocent victims" from others afflicted with AIDS.⁶

Many hemophiliacs disagreed, believing that they should focus on getting compensation for themselves.

Some believed that the NHF had become too close to the pharmaceutical companies; in fact, the NHF was largely funded by pharmaceutical companies.

Frustration with the National Hemophilia Foundation's conservatism led another group of hemophiliacs to split off and form the Committee of Ten Thousand ("COTT"). COTT, whose name referred to the roughly 10,000 American hemophiliacs then believed to be suffering from HIV-related illnesses, began lobbying for compensation. Activists also formed another group, the Hemophilia/HIV Peer Association, which was even more aggressive in pursuing accountability. The groups fought openly: the leader of the Hemophilia/HIV Peer Association went so far as to call the former director of the National Hemophilia Foundation (NHF) "the Josef Mengele of the hemophilia holocaust."⁷

Both of these two splinter groups were instrumental in generating public outrage about the scandal, and in organizing hemophiliacs to press for compensation. These efforts culminated in 1993, when these two groups successfully filed a class action lawsuit against five blood fractionators and the National Hemophilia Foundation.⁸ However, the infighting within and between groups continued, and as a result some victims who held out for larger and larger settlements made it nearly impossible for settlements to be reached.

Hemophilia groups separated themselves from other groups representing people living with HIV/AIDS by framing hemophiliacs with HIV/AIDS as "undeserving" victims.⁹ This created more public sympathy with hemophiliacs, but unfortunately only reinforced the stigma surrounding HIV/AIDS. As a result of this tactic and the lack of unity between US NGOs, the US' compensation policy discriminated against those who contracted HIV/AIDS from blood transfusions by not awarding them any compensation for the collection and distributions of a HIV/AIDS tainted blood supply.

For Chinese AIDS and hemophilia NGOs, the lesson from other countries is that working together collaboratively and in solidarity can speed progress to the common goal of winning compensation for victims.

VII. CONCLUSION

As should be seen from this report, the process of learning about how to regulate and control blood supplies, and about how to address blood supply problems, has progressed slowly. However, the learning curve has been similar in each country.

Denial is tragically all too common to governments in the early stage of the AIDS epidemic. Denial by the Reagan administration certainly slowed the response of the U.S. to AIDS in the 1980s, resulting in the loss of life of many and fueling the global epidemic. The U.S.' own compromised blood supply infected blood supplies in other countries. Some countries, such as China, reasonably fearing contamination by U.S. blood, relied exclusively on internal blood supplies with equally disastrous results. In many countries, close links between the blood industry, the pharmaceutical industry, and government regulators, proved disastrous for national blood safety. All the countries discussed here were reluctant to confront their own AIDS blood transmission disasters, and ultimately did so only because of pressure from grassroots NGOs, a torrent of litigation, and embarrassing, negative media reports.

However, because other countries have walked this road already, there is a clear record in terms of which measures have proven successful in resolving the crisis. Each of the countries discussed here held a national-level investigation; established compensation funds for victims; and took measures to centralize and streamline their blood supply systems. These efforts reinforce each other and create an environment

conducive to preserving blood safety.

Because the countries discussed here took these measures early on, each country was able to minimize the time and resources spent in litigation, bring closure to their tragedies, and ensure that the disasters were not repeated. With a high-level commitment to ensuring blood safety and international assistance, China can do the same.

APPENDIX

Four Free, One Care Program

In 2003, central authorities announced the launch of the “Four Free, One Care” AIDS policy [四免一关环], which has since been expanded to a total of 127 sites nationwide. Under this policy, the Chinese government pledged to provide:

- Free antiretroviral drugs to AIDS patients who are rural residents or people without insurance living in urban areas;
- Free voluntary counseling and testing;
- Free drugs to HIV-infected pregnant women to prevent mother-to-child transmission, and HIV testing of newborn babies;
- Free schooling for children orphaned by AIDS; and
- Care and economic assistance to the households of people living with HIV/AIDS.

In the same year, with support from the Global Fund to Fight AIDS, Tuberculosis and Malaria, China initiated the China CARES project, “an extensive community-based HIV treatment, care and prevention program” targeting regions hit hardest by the contaminated blood supply problem: Anhui, Hebei, Shandong, Henan, Hubei, Shanxi, and Shaanxi.¹ This grant aimed to strengthen the free antiretroviral treatment program.²

While these programs have brought antiretroviral treatment to many—currently, 20,453 people with AIDS are receiving antiretroviral therapy in China--the Chinese Ministry of Health acknowledges that implementation of the “Four Free, One Care” policy has been uneven.³ Early on, many patients developed serious side effects common to antiretroviral treatment, and because medical personnel were inadequately trained to counsel patients about the side effects, many patients stopped treatment. This created the risk early on that drug-resistant strains of HIV could develop.⁴

In addition, Medecins Sans Frontieres notes that because of Glaxo-Smith Kline’s monopoly, fixed-dose combinations are unavailable, and second-line drugs are also not available. Pediatric antiretroviral medications are “only available on a limited basis.”⁵

ACKNOWLEDGMENTS

This report was written by Evan Anderson and Sara Davis. The authors gratefully acknowledge the advice and assistance of the following people and organizations: Aizhixing Research Institute, Scott Burris, Jonathan Cohen, Joanne Csete, the Korekata AIDS Law Center, Medecins Sans Frontieres (China), Michael Orsini, Sophie Richardson, Lori Stoltz, and UNAIDS (China). Of course, none of these persons or organizations are responsible for any remaining errors. Special thanks to Shen Tingting, Zhang Junmei, and Emmanuelle Lyon for assistance with translation into Chinese and French. Funding for the report was provided by Levi Strauss Foundation, the Open Society Institute, and the U.S.-China Legal Cooperation Fund.

ABOUT ASIA CATALYST

asia catalyst partners with activists in Asia to inspire, create and launch innovative, self-sustaining programs and organizations that advance human rights, social justice and environmental protection. We link up Asian community leaders, journalists, activists, and lawyers with each other and with international experts who can help them to realize their visions.

We incubate programs that may be too risky or innovative for established organizations to take on. We strategize with international organizations to develop creative, effective campaigns for social justice in Asia. For more information, please see www.asiacatalyst.org.

NOTES

I. SUMMARY

¹ "Nation in Crucial Period for AIDS Prevention," Xinhua News Agency, April 8, 2004; <http://www.china.org.cn/english/government/92498.htm>, retrieved August 9, 2007.

II. THE BLOOD SCANDALS

¹ The unique nature of the blood scandals as a repeating international phenomenon has been seized upon by comparative legal scholars as an opportunity to compare how different nations handle similar, yet extensive, legal challenges. However, whereas these papers generally focused on a few selected countries and did so with the goal of understanding how national idiosyncrasies animated differences in how these countries created and then grappled with the outbreak of HIV/AIDS in their respective blood supplies, this report aims to discern not why blood scandals unfolded as they did in different countries, but rather which actions by the various countries were successful and may accordingly be applied to China. See e.g., Eric A. Feldman, "Blood Justice: Courts, Conflict, and Compensation in Japan, France, and the United States," *Law & Society Review* 34 (2000): 651-701; Joseph Kelly, "The Liability of Blood Banks and Manufacturers of Clotting Products to Recipients of HIV-infected Blood: A Comparison of the Law and the Reaction in the United States, Canada, Great Britain, Ireland and Australia," *John Marshall Law Review* 27 (1994): 465-491; Michael Trebilcock, Robert Howse & Ron Daniels, "Do Institutions Matter? A Comparative Pathology of the HIV-infected Blood Tragedy," *Virginia Law Review* 82 (1996): 1407-1492; Francine A. Hochberg, "HIV/AIDS and Blood Donation Policies: A Comparative Study of Public Health Policies and Individual Rights Norms," *Duke Journal of Comparative & International Law* 12 (2002): 231-279.

² Feldman, "Blood Justice," p. 660.

³ For a comprehensive and highly readable history of the science and business of blood, see Douglas Starr, *Blood: An Epic History of Medicine and Commerce* (New York: Knopf Press, 1998).

⁴ James P. AuBuchon et al., "Safety of the Blood Supply in the United States: Opportunities and Controversies," *Annals Internal Medicine* 127 (1997): 904-909. According to the authors, in the United States, "Expansion of blood donor screening and improvements to laboratory markers have reduced the risk for HIV infection from as high as 1 in 100 units in some U.S. cities in the early 1980s to approximately 1 in 680,000 units. Transfusion-related hepatitis has also almost been vanquished: Transmission rates for hepatitis C virus (HCV) has decreased from 1 in 200 units in the early 1980s to approximately 1 in 100,000 units today..." AuBuchon et al. "Safety," p. 904.

⁵ See e.g., S.A. Larsson, "Life expectancy of Swedish haemophiliacs, 1831-1980." *British Journal of Haematology*. 59 (1985): 593-602.

⁶ Eric Feldman & Ronald Bayer, *Blood Feuds: AIDS, Blood, and the Politics of Medical Disaster* (New York: Oxford University Press, 1999): 20.

⁷ As was later the case in France and Canada, controversy arose over calls by some to exclude men who have sex with men from blood donation. Gay rights advocates argued that such policies were degrading, stigmatizing and discriminatory (Starr, *Blood*, 271, 274).

⁸ Feldman and Bayer, *Blood Feuds*, 64.

⁹ Or 3,725 hemophiliacs. Feldman & Bayer (*Blood Feuds*, p. 35) citing unpublished data from the Centers for Disease Control and Prevention.

¹⁰ Feldman & Bayer, 33.

¹¹ *Ibid.*, 40-48.

¹² Lauren B. Leveton, Harold C. Sox, Jr., & Michael A. Stoto, "HIV and the Blood Supply: An Analysis of Crisis Decision-making," (Committee to Study HIV Transmission Through Blood and Blood Products, Institute of Medicine (IOM), 1995); available at <http://books.nap.edu/openbook.php?isbn=0309053293>, retrieved June 1, 2007.

¹³ Feldman & Bayer, *Blood Feuds*, 43.

¹⁴ *Ibid.*, 33-34. Some studies have established that in certain areas in the United States almost 90% of the hemophilia patients who were to contract HIV/AIDS through transfusions did so by January 1983, the date of CDC's first published meeting on blood-transfusion-associated AIDS. Because of the long gestation period for AIDS, the number

of those who had contracted HIV/AIDS jumped sharply from 561 cases amongst blood transfusions recipients and hemophiliacs in 1985 to more than 12,000 cases by 1995.

¹⁵ Starr, *Blood*, 338. Similar statements are offered by other scholars including Trebilcock, who notes that “perhaps the most striking fact [regarding the blood scandals] is that with respect to almost every stage of the escalating sequence of precautionary interventions taken to enhance the safety of the national blood systems, the United States moved first...” (Trebilcock, “Do Institutions Matter?” 1479).

¹⁶ Feldman & Bayer, *Blood Feuds*, 33.

¹⁷ *Ibid.*, 64.

¹⁸ *Ibid.*, 67.

¹⁹ Feldman, “Blood Justice,” 678.

²⁰ Starr, *Blood*, 282. Starr notes, “Abe was a legendary figure among hemophiliacs in Japan. In a culture where disability meant disgrace, Abe treated his patients with dignity, extending to them the right to be rehabilitated, not scorned. When Factor VIII came on the market, he enthusiastically promoted it, becoming the nation’s pioneer in hemophilia care. He and a couple of colleagues had traveled the country, bringing therapy to urban and rural populations alike.”

²¹ In 2001, Dr. Abe was cleared of these charges when a Japanese judge found that his actions were not criminally unreasonable given the scientific uncertainty regarding blood at the time. (“International Update on Litigation on Blood and Blood Products: Japan: Court Clears Doctor, Convicts Former Health Ministry Official for Negligence in HIV-Tainted Blood Products,” *Canadian HIV/AIDS Policy & Law Review*, 6 (2002): 77-78.)

²² Starr, *Blood*, 303-305.

²³ *Ibid.*, 305.

²⁴ *Ibid.*, 306.

²⁵ Feldman & Bayer, *Blood Feuds*, 341.

²⁶ Feldman, “Blood Justice,” 678.

²⁷ *Ibid.*

²⁸ Feldman & Bayer, *Blood Feuds*, 109.

²⁹ As with the United States, in France, early calls by epidemiologists to limit or exclude men who have sex with men from donating blood met strong resistance from gay rights organizations, which in turn delayed the adoption of donor screening regulations. Feldman, “Blood Justice,” 662.

³⁰ A few years earlier, disagreement between French and American doctors over who had discovered the HIV virus produced a nasty professional feud. *Ibid.*, 686.

³¹ *Ibid.*

³² Alan Riding, “France approved use of AIDS-tainted blood,” *New York Times*, October 20, 1991, <http://query.nytimes.com/gst/fullpage.html?sec=health&res=9D0CE7DB1E3DF933A15753C1A967958260>, retrieved September 2, 2007.

³³ *Ibid.*, 689.

³⁴ *Ibid.*

³⁵ Mike Ingram, “Court acquits former prime minister,” World Socialist Website, March 12, 1999, <http://www.wsws.org/articles/1999/mar1999/hiv-m12.shtml>, retrieved September 2, 2007.

³⁶ Feldman & Bayer, *Blood Feuds*, 141.

³⁷ As Douglas Starr notes, “The Canadians’ performance with whole blood was no better. Like the French, they were slow to use questionnaires, fearing an infringement on their donors’ rights and privacy.” Starr, *Blood*, 302.

³⁸ Krever Report, 293.

³⁹ Starr notes, “Later, when ELISA became available, they were slow to adopt it as well, hampered by bureaucratic and budgetary delays. Even though virtually all U.S. blood banks were using the test by late March 1985, the Canadians did not do so until the following November. According to [one study]...fifty-five transfusion recipients were infected by blood that could have been eliminated.” (Starr, *Blood*, 302.)

⁴⁰ See Krever Report, note 39 *infra*, 284.

⁴¹ Krever Report, 405.

⁴² Starr, *Blood*, 302.

⁴³ Ken Nyhuus, “Government says no to inquiry into blood supply,” CBC, November 18, 1992, <http://archives.cbc.ca/500f.asp?id=1-70-737-4474>, retrieved September 2, 2007.

⁴⁴ On November 26, 1997, Health Minister Allan Rock, on behalf of the federal government, released the final report

of the Commission of Inquiry on the Blood System in Canada (“Krever Report”), available at http://www.hc-sc.gc.ca/ahc-asc/activit/com/krever_e.html, retrieved August 19, 2007.

⁴⁵ Electronic mail correspondence with Michael Orsini, political science professor and expert on Canadian blood disaster, July 29, 2007.

⁴⁶ Karen Capen, “Krever can name names, Supreme Court rules”, *Canadian Medical Association Journal*, (November 1, 1997) 157.9: 1265.

⁴⁷ Electronic mail correspondence with Lori Stoltz, Canadian AIDS law expert, August 31, 2007.

⁴⁸ “Red Cross Pleads Guilty to Distributing Tainted Blood,” *HIV/AIDS Policy Law Review, HIV in the Courts: Canada*, 10 (2005): 45.

⁴⁹ “Red Cross Pleads Guilty.”

⁵⁰ Patricia Volkow, “The Mexican experience with the impact of banning the blood-plasma trade in preventing HIV transmission: ‘What history ignores is meant to be repeated,’” *AIDS: Volume 17* (2003): 1263-1264.

⁵¹ “Dutch face up to blood scandal,” *British Medical Journal* (August 5, 1995): 311-347.

⁵² K.S. Jayaraman, “HIV Scandal Hits Bombay blood centre,” *Nature* 376 (1995): 285.

⁵³ In Kenya, a 2001 study discovered that 6.4% of all blood donors had HIV/AIDS. Moore et al., “Estimated risk of HIV transmission by blood transfusion in Kenya,” *Lancet* 358 (2001): 657-660.

⁵⁴ More than a hundred children contracted HIV/AIDS through blood transfusions in Shymkent, Kazakhstan. Criminal convictions and resignations of government officials have resulted. Maria Golovina, “Health workers jailed in Kazakh baby AIDS death case,” Reuters, June 27, 2007; available at <http://www.reuters.com/article/latestCrisis/idUSL27767557>; retrieved on August 12, 2007.

⁵⁵ Although the reasons are a source of much controversy, 426 children contracted HIV/AIDS in a Libyan hospital, resulting in a lengthy prosecution and the trial of five Bulgarian nurses who were ultimately convicted, sentenced to death, and subsequently released back to Bulgaria. Elisabeth Rosenthal, “Quiet. Libya Has an AIDS Problem”, *New York Times*, July 29, 2007. Available at <http://www.nytimes.com/2007/07/29/weekinreview/29rosenthal.html?ex=1188705600&en=a4def2001fd83eec&ei=5070> retrieved on August 15, 2007.

III. CHINA’S EXPERIENCE

¹ Wu Zunyou, Sheena G. Sullivan, Wang Yu, Mary Jane Rotheram-Borus, and Roger Detels, “Evolution of China’s Response to HIV/AIDS,” *Lancet* 2007; 369:679-690. Available at <http://www.thelancet.com/journals/lancet/article/PIIS0140673607603158/fulltext#section13>; retrieved July 16, 2007.

² He Aifeng essay; “Deadly Secret: AIDS in China,” CBC News, August 11, 2006, <http://www.cbc.ca/news/background/aids/aids-china.html>, retrieved July 18, 2007.

³ Wu Zunyou, Rou Keming, and Roger Detels, “Prevalence of HIV infection among former commercial plasma donors in rural eastern China.” *Health Policy Plan 2001*; 16:41-6. Available at <http://heapol.oxfordjournals.org/cgi/reprint/16/1/41>, retrieved July 16, 2007.

⁴ Wu et al, “Prevalence of HIV infection.”

⁵ Charles Hutzler, “Blood Problems, Poverty Point to AIDS Outbreak in China,” Associated Press, November 5, 1995, summary accessed at www.casy.org, July 26, 2007; “‘Expert’ Says ‘High Risk’ of Contracting AIDS in China,” *Zhongguo Tongxun She* (Hong Kong), February 19, 1993; summary accessed at www.casy.org, July 26, 2007; “To Raise Awareness of AIDS,” Xinhua, December 1, 1994; summary accessed at www.casy.org, July 26, 2007.

⁶ H.A. Goubran, T. Burnouf, M. Radosevich, “Virucidal heat-treatment of single plasma units: a potential approach for developing countries.” *Haemophilia* (November 2000) 6.6: 597-604.

⁷ Didi Kirsten Tatlow, “AIDS Specialist Warns China’s AIDS Blood System Vulnerable to HIV,” Associated Press, November 18 1996, <http://www.newsr.com/newsletters/AIDS-Weekly/1996-11-18/199611183339AW.html>, retrieved August 9, 2007.

⁸ “Officials say Most China Provinces Could Have AIDS from Blood Selling,” Agence France Presse, March 3, 2003, www.who.int/disasters/repo/12407.pdf, retrieved August 9, 2007; “China’s Full-Blown AIDS to Double to 200,000 in Five Years: Report,” Agence France Presse, January 13, 2003, retrieved at www.casy.com, August 9, 2007.

⁹ Elisabeth Rosenthal, “Spread of AIDS in Rural China Ignites Protest,” *New York Times*, December 11, 2001.

¹⁰ *Locked Doors: The human rights of people living with HIV/AIDS in China*, Human Rights Watch Report, August 2003, <http://www.hrw.org/reports/2003/china0803/>, retrieved August 9, 2007. The author of that report, Sara Davis, is

also one of the authors of this report.

¹¹ *2005 update on the HIV/AIDS epidemic and response in China*. Ministry of Health of China, UNAIDS, WHO joint report. Beijing: Ministry of Health, 2006.

¹² Bates Gill, Yanzhong Huang, and Xiaoqing Lu, *Demography of HIV/AIDS in China*, Center for Strategic and International Studies Task Force on HIV/AIDS, July 2007.

¹³ Elizabeth Rosenthal, "In Rural China, A Steep Price of Poverty: Dying of AIDS," *New York Times*, October 28, 2000, p. A1. In response to demand for an accurate estimate of HIV prevalence in Henan, in July 2004 China announced an official survey of AIDS prevalence in the province that was scheduled for completion by April 2005 ("Blood Survey to Bring AIDS Prevalence to Light," *China Daily*, October 4, 2004.) The survey ended early, in November 2004, and concluded that there were only 25,036 people with AIDS in Henan—mysteriously, exactly the same number as before the survey was completed ("Survey: 25000+ HIV in Henan", *China Daily*, November 16, 2004, <http://china.org.cn/english/2004/Nov/112318.htm>).

¹⁴ Jonathan Watts, "China bans negative reporting ahead of party congress," *Guardian*, August 17, 2007.

¹⁵ "China Sets Up Blood Testing to Battle AIDS," *Deutsche Presse-Agentur*, 14 April 1995.

¹⁶ Charles Hutzler, "Blood Problems, Poverty Point to AIDS Outbreak in China," *Associated Press*, 5 November 1995.

¹⁷ Goubran et al, below, 2000

¹⁸ "China Seeks to Ensure Safety of Blood Products," *Agence France Presse*, 5 January 1997.

¹⁹ "Blood Law Set for Implementing; Voluntary Donors to be Target," *China Daily*, 22 September 1998.

²⁰ 130 People Contract AIDS from Blood Transfusions," *Financial Times*, 1 January 1999.

²¹ "China to intensify crackdown on fake medicine." Reuters. January 7, 1997.

<http://www.aegis.com/news/re/1997/RE970114.html>, retrieved July 23, 2007; Leigh, Jenkins, "Chinese Health Experts Blame 'Little, Late' Government Efforts to Fight AIDS," *South China Morning Post*, 11 August 2001; "Nation in Crucial Period for AIDS Prevention," Xinhua News Agency, 8 April 2004; Zhang Feng, "Suppliers of Blood Under Investigation," *China Daily*, 30 July 2004, p. 1; "China closes blood agencies to curb AIDS," *China Daily*, March 28, 2005; "China Arrests 15 in AIDS Crackdown", *Washington Post*, April 13, 2005.

²² "PRC Urges More Blood Donations to Reduce HIV/AIDS Risk," *Xinhua*, 13 December 2001.

²³ "Donation Vital to Blood Safety: Health Officials," *Xinhua News Agency*, April 7, 2000; www.casy.org/chron/BloodSupply.htm, retrieved September 2, 2007.

²⁴ "China says faces threat from illegal blood sales," Reuters, June 14, 2007, <http://www.netscape.com/viewstory/2007/06/14/china-says-faces-threat-from-illegal-blood-sales/?url=http%3A%2F%2Fwww.reuters.com%2Farticle%2FhealthNews%2FidUSPEK766120070614&frame=true>, retrieved September 2, 2007.

²⁵ "China Faces Uphill Battle to Stop Deadly Blood Sales" ; "College Students Among Sellers of Blood to Make Money," *Agence France Presse*, December 7, 2003; retrieved at www.casy.com, September 2, 2007.

²⁶ Zhang Feng, "Suppliers of Blood Under Investigation," *China Daily*, July 30, 2004, retrieved http://www.chinadaily.com.cn/english/doc/2004-07/30/content_353069.htm, retrieved August 19, 2007.

²⁷ Zhang, "Suppliers of Blood."

²⁸ These numbers include both those infected through blood donations and those infected through transfusions. Chinese AIDS advocates and doctors have alleged that the true number may be much higher. UNAIDS, WHO, MOH 2005, p. 1.

²⁹ "Blood center licenses will be revoked if they fail to meet regulations," June 14, 2007, <http://english.pravda.ru/news/society/14-06-2007/93357-blood-0>, retrieved July 23, 2007.

³⁰ "China orders video monitoring of blood collection", Reuters, July 11, 2007, <http://www.reuters.com/article/healthNews/idUSPEK6700020070711>, retrieved July 23, 2007

³¹ ("China-grown pharma products," *Genetic Engineering & Biotechnology News*, Nov 15 2006 (Vol. 26, No. 20)

³² ("China Blood Product Industry Report, 2006-2007 Is Available Now", *Biotech Finances*, http://www.biotech-finances.com/?page=cp&cp_id=18068&cp_page_nb=3, retrieved July 23, 2007

³³ "AIDS Group Sends Letter to Wu Yi Urging Release of Statistics," *Agence France Presse*, 11 July 2003

³⁴ Li Fangping, "Using the case of Liu Xianhong to understand the limits of AIDS litigation", talk abstract, *Korekata AIDS Law Center journal 1*, August 2007, 18-19; Zhu Bingjin, "The case of the 68 PLWHA from Soudengzhan township, Jilin City", talk abstract, *Korekata AIDS Law Center journal 1*, August 2007,16; *AIDS litigation compendium*, Aizhixing Research Institute, February 2005; *2006 annual report on AIDS law and human rights*,

Aizhixing Research Institute, March 2007.

³⁵ The Korekata AIDS Law Center is a joint project of Asia Catalyst and China Orchid AIDS Projects.

³⁶ Li Fangping, "Using the case of Liu Xianhong to understand the limits of AIDS litigation," talk text on file with Asia Catalyst.

³⁷ Li Xige, "Open letter to President Hu Jintao."

³⁸ "China bans AIDS rights meeting, group says," Reuters, July 29, 2007.

³⁹ Interview with Li Dan, July 25, 2007.

⁴⁰ Li Fangping, "Using the case of Liu Xianhong."

⁴¹ 2006 年中国艾滋病法律人权报告: 北京爱知行研究所的经验 [2006 Annual AIDS, Law and Human Rights Report: The Experience of the Beijing Aizhixing Research Institute], Beijing Aizhixing Research Institute, March 2006; p. 24.

⁴² "Shanghai Attorney in Plea for AIDS Law," *Shanghai Daily*, November 27, 2003; <http://www.china.org.cn/english/government/81025.htm>, retrieved August 9, 2007.

⁴³ "襄樊将建立专项基金救助输血感染艾滋病的患者" [Xiangfan to establish fund to assist people infected with HIV/AIDS through blood transfusion], *Chutian Urban Daily*, June 28, 2007.

⁴⁴ Liisa Seim and Alana Klein, "China: Hospital to Compensate 19 People Infected with HIV Through Blood Transfusions," *HIV Policy and Law Review* 12.1 (May 2007), p. 54.

⁴⁵ "中国血友病人感染HIV/HCV情况: 资料汇编" [Situation Regarding Hemophiliacs Infected with HIV/HCV in China], 北京爱知行研究所[Aizhixing Research Institute], October 2006; p. 4.

⁴⁶ "Situation Regarding Hemophiliacs Infected with HIV/HCV in China," p. 15.

⁴⁷ Vivien Cui, "Time Runs Out for AIDS Scandal Victims," *South China Morning Post*, March 1, 2004, summary accessed at www.casy.org, August 9, 2007.

⁴⁸ Interview with Wan Yanhai, July 26, 2007

⁴⁹ "Shanghai tackles tainted blood," *China Daily*, December 2, 2003;

http://www.chinadaily.com.cn/en/doc/2003-12/02/content_286344.htm, retrieved August 5, 2007.

⁵⁰ Benjamin Morgan, "Shanghai HIV/AIDS Victims Accuse PRC Government of Negligence," Agence France Presse, January 19, 2003, summary accessed at www.casy.org, August 9, 2007.

⁵¹ "Situation Regarding Hemophiliacs..." p. 16.

IV. LEGAL ISSUES

¹ Article 25(1), Universal Declaration of Human Rights, adopted by the United Nations on December 10, 1948; available in English at <http://www.unhchr.ch/udhr/lang/eng.htm>, 中文<http://www.unhchr.ch/udhr/lang/chn.htm>.

² Article 12, International Covenant on Economic, Social and Cultural Rights, adopted by the United Nations on December 16, 1966, ratified by China on June 27, 2001; available in English at http://www.unhchr.ch/html/menu3/b/a_cescr.htm, 中文 http://news.xinhuanet.com/ziliao/2003-01/20/content_698236.htm.

³ U.N. Committee on Economic, Social and Cultural Rights, General Comment 14, "The right to the highest attainable standard of health," U.N. Doc. E/C.12/2000/04 (2000); Section I paragraph 12(a); available in English at [http://www.unhchr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En?OpenDocument](http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument).

⁴ U.N. CESCR, General Comment 14, paragraph 31.

⁵ 血战管里办法 [Blood Station Management Law], People's Republic of China Ministry of Health Order number 44, implemented March 1, 2006; 艾滋病防治条例 [AIDS Prevention Act], ratified by the 122nd meeting of the State Council, January 18, 2006, to be implemented March 1, 2006,

⁶ Article 6 of the *Blood Station Management Law* stipulates that the Ministry of Health manages all blood stations, while local governments at the county level and above manage the work of the blood stations. Article 8 states that provincial governments are responsible for giving permission to blood stations. Article 12 states that provincial, prefectural and municipal governments should unify and coordinate all testing and planning. However, dispersing authority between so many agencies in practice creates obstacles to the streamlining of blood testing.

⁷ "Chinese court slaps prison terms over hospital AIDS contamination," Kyodo News (Tokyo), in *Japan Today*, January 29, 2005, http://findarticles.com/p/articles/mi_m0WDP/is_2005_Jan_31/ai_n9476278, retrieved September 2, 2007.

⁸ Universal Declaration of Human Rights, General Assembly Resolution 217A (III), December 10, 1948, art. 8.

⁹ UNCESCR, General Comment 14, paragraph 59. Similar language also exists in the General Comment on Article 2 of the ICCPR. See: U.N. Human Rights Committee, *General Comment No. 31 on Article 2 of the Covenant: The Nature of the General Legal Obligation Imposed on States Parties to the Covenant*, U.N. Doc. CCPR/C/74/CRP.4/Rev.6 (2004), para. 16.

¹⁰ Commission on Human Rights, “Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Violations of International Human Rights and Humanitarian Law,” (United Nations: Geneva, 2000), E/CN.4/2000/62, article 11; available in English at <http://www.ohchr.org/english/law/remedy.htm>.

¹¹ Krever Report, 782.

¹² Feldman & Bayer, *Blood Feuds*, 37 citing C.Kelley & J.P.Barber, “Legal Issues in Transfusion Medicine: Is Blood Banking a Medical Profession?” *Selected Topics in Laboratory Medicine*, 12 (1992): 832.

¹³ Feldman & Bayer, *Blood Feuds*, 116.

¹⁴ Wang Weijun case narrative on file with Asia Catalyst.

¹⁵ “HIV Boy Loses China Hospital Case,” *BBC News*, December 30, 2005; <http://news.bbc.co.uk/2/hi/asia-pacific/4569866.stm>, retrieved August 9, 2007.

¹⁶ Interview with Wan Yanhai, July 26, 2007.

¹⁷ “China Highlights Dangers and Promotes Prevention on World AIDS Day,” Associated Press, December 1, 2006; <http://english.sina.com/china/1/2006/1201/96638.html>, retrieved August 9, 2007.

¹⁸ Starr, *Blood*, 322-323, 337.

V. COMPENSATION

¹ Krever Report, 892. For the purpose of consistency and because it is most recent comprehensive study of compensation funds, we use the statistics in the Krever Commission.

² *Ibid.*

³ *Ibid.*, 893.

⁴ *Ibid.*, 1032.

⁵ *Ibid.*

⁶ *Ibid.*, 838.

⁷ *Ibid.*, 839.

⁸ *Ibid.*, 876.

⁹ *Ibid.*, 801.

¹⁰ *Ibid.*, 802.

¹¹ *Ibid.*, 781.

¹² Commission on Human Rights, “Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Violations of International Human Rights and Humanitarian Law,” (United Nations: Geneva, 2000), E/CN.4/2000/62; available in English at <http://www.ohchr.org/english/law/remedy.htm>.

¹³ Basic Principles and Guidelines, article 20.

¹⁴ Basic Principles and Guidelines, article 21.

¹⁵ *Ibid.*, article 22.

VI. THE ROLE OF GRASSROOTS NGOS

¹ Michael Orsini, “Reframing Medical Injury? Viewing People With Hemophilia as Victims of Cultural Injustice,” *Journal of Social and Legal Studies* 16 (2007): 241-258; David L. Kirp, “Look Back in Anger: Hemophilia and AIDS Activism in the International Tainted-Blood Crisis,” *Journal of Comparative Policy Analysis* 1 (1999): 177-202.

² The dramatic media coverage and public outrage over the blood scandals in France and Japan, where comprehensive legal battles were largely successful, was markedly different than the relative ambivalence of the media and the public in the United States. Feldman, “Blood Justice,” 674.

³ Feldman, “Blood Justice,” 673.

⁴ Kirp, “Look Back in Anger,” 185.

⁵ *Ibid.*

⁶ Feldman & Bayer, *Blood Feuds*, 46.

⁷ Feldman, *Blood Justice*, 673.

⁸ *Ibid.*, 674.

⁹ Feldman & Bayer, *Blood Feuds*, 90.

APPENDIX

¹ “China signs \$32 million AIDS grant with Global Fund,” press release, August 19, 2004, http://www.theglobalfund.org/en/media_center/press/pr_040819.asp, retrieved August 2, 2007.

² Kaisernetwork.org, “Global fund awards China M for HIV/AIDS prevention, treatment efforts”, November 14, 2003.

³ UNAIDS 2005, p. iii.

⁴ Hoo S. (2003) “Clinton Urges US, China to overcome Trade Row”, Associated Press, November 11, 2003; “China starts offering free AIDS drugs but lacks doctors to administer them,” Agence France Presse, July 14, 2003.

⁵ “Access to Essential HIV/AIDS Medicines in China,” Medecins Sans Frontieres brochure.